

**NHS Bedfordshire, Luton
and Milton Keynes
Integrated Care Board
GOVERNANCE HANDBOOK**

Document Control Sheet

Version	Date	Reviewer(s)	Revision Description
v1.0	01-07-2022	Board of the Integrated Care Board	Approved
v2.0	29-07-2022	Board of the Integrated Care Board	Approved amendments to committee terms of reference
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V9.0	8-12-2024	Board of the Integrated Care Board	Amendments to Primary Care Commissioning and Assurance Committee Terms of Reference
V10.0	22-3-2024	Board of the Integrated Care Board	Amendments to take account of the delegation of specialised commissioning.

			<p>Added terms of reference for the ICB Provider Selection Regime (PSR) Review Group</p> <p>Changes to Primary Care Commissioning and Assurance Committee Terms of Reference</p> <p>Addition of Primary Care Delivery Group Terms of Reference</p> <p>Changes to Bedford Borough Council Health and Wellbeing Board Terms of Reference</p> <p>Amendments to job titles</p>
V11.0	19.07.2024	Board of the Integrated Care Board	<p>Addition of Mental Health Learning Disability and Autism Committee Terms of Reference</p> <p>Amendment to Finance & Investment Committee membership</p> <p>Amendment of Quality and Performance Committee Quoracy</p> <p>Deletion of Working with People and Communities Committee</p> <p>SoRD updated to include signing of Place Better Care Fund agreements</p> <p>Updates on Health & Wellbeing Board and Place Board Terms of Reference (local approval, not ICB Board).</p>
V12.0	27.09. 2024	Board of the Integrated Care Board	<p>Appendix Q – Chief Nursing Director Board lead for Safeguarding (all ages) including looked after children and care leavers.</p> <p>SORD – approval of arrangements for statutory consultation and / or engagement in relation to proposed service change delegated to Quality & Performance Ctte</p> <p>Para 2.5 and Annex 1 – ICB Committee structure updated to reflect Mental Health, Learning Disabilities & Autism Collaborative Committee being established and Working with People &</p>


			Communities Committee being dissolved.
V13.0	13.12.2024	Board of the Integrated Care Board	Quality and Performance Committee Terms of Reference para 6.3.5 – responsibility for approval of Evidence Based Policies changed to ICB Executive Group

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Glossary of Terms

Term	Definition
Board-level	An individual who has a designated / speciality role required at board level, who may not be a Board member. This may include band 9 directors under the NHS Agenda for Change pay framework or very senior managers (VSM).
Committee	A committee created and appointed by the Board of the Integrated Care Board.
Integrated Care Board	The legal entity with responsibility for a geographical area that the Integrated Care Board has responsibility for, as defined in section 2 of the Constitution.
Integrated Care Partnership	The joint committee for the Integrated Care Board's area established by the Integrated Care Board, and each responsible local authority whose area coincides with or falls wholly or partly within this.
Place-Based Link Executives	A lead executive from the Integrated Care Board who is the conduit to local Place-based arrangements
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government, and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by primary care network clinical directors or other relevant primary care leaders.
Sub-Committee	A committee created and appointed by and reporting to a committee.
VCSE	Voluntary, community and social enterprise sector

1.0 Introduction

1.1 The Governance Handbook is a companion document to the Constitution, and provides additional supplementary information to NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB), about how the organisation will conduct its affairs and the arrangements for the exercise of its functions.

1.2 Authority to Act

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

- a) Its Board.
- b) A committee or sub-committee of the Board.
- c) Any of its Board members or employees.
- d) Board-level roles.

1.3 Establishment

1.3.1 The Board of the ICB has established several committees to assist it with the discharge of its functions and may authorise the establishment of other committees or sub-committees or other assurance groups.

1.3.2 Only a committee of the Board of the Integrated Care Board may be named as a committee.

1.3.3 No committees, sub-committees or other groups shall be established without appropriate authorisation in line with the Scheme of Reservation and Delegation.

1.3.4 The Governance Handbook contains information relating to the establishment of the committees, sub-committees, joint committees and consultative forums of the ICB only.

1.3.5 The ICB has agreed a set of Standing Orders which describe the processes that are employed to undertake its business, and form part of the Constitution.

1.3.6 They include procedures for:

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

1.4 Confidentiality

- 1.4.1 All members and attendees of the Board, its committees and sub-committees, including joint committees and consultative forums are required to follow the NHS information governance rules on confidentiality. These principles must be observed by all who work within the Integrated Care Board and have access to its person information or confidential information.
- 1.4.2 All members and attendees are also obliged to follow the common law duty of confidentiality. Common law requires there to be a lawful basis for the use or disclosure of personal information that is held in confidence, for example:
- Where the individual has capacity and has given valid informed consent.
 - Where disclosure is in the overriding public interest.
 - Where there is a statutory basis or legal duty to disclose, e.g., by court order.

2.0 Committees of the Board of the Integrated Care Board

2.1 Statutory Committees

- 2.1.1 The Board of the ICB has resolved to establish the following statutory committees:
- Audit and Risk Assurance.
 - Remuneration.

2.2 Audit and Risk Assurance Committee

- 2.2.1 This committee is accountable to the Board of the ICB and provides an independent and objective view of the ICB's compliance with its statutory responsibilities, including risk management. The Committee is responsible for arranging appropriate internal and external audit.
- 2.2.2 The Committee will be chaired by an independent non-executive member (other than the Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters. The Committee's terms of reference are at Appendix A of the Governance Handbook.

2.4 Remuneration Committee

- 2.4.1 This committee is accountable to the Board of the ICB for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.
- 2.4.2 The Committee will be chaired by an independent non-executive member. The Committee's terms of reference are at Appendix C of the Governance Handbook.

2.5 Non-Statutory Committees

2.5.1 The Board of the ICB has also resolved to establish the following non-statutory committees:

- Bedfordshire Care Alliance.
- Finance and Investment.
- Mental Health, Learning Disabilities and Autism Committee
- Primary Care Commissioning and Assurance.
- Quality and Performance

2.6 Joint Committees

2.6.1 The Board of the ICB has also resolved to establish the following joint committee:

- Bedfordshire, Luton and Milton Keynes Health and Care Partnership (Integrated Care Partnership).

2.7 Consultative Forums (emergent)

2.7.1 The Board of the ICB will engage with its partners to discuss and agree shared strategic direction together through the following forums. These forums will inform and align decisions by relevant statutory bodies in an advisory role, unless specific ICB functions have been delegated to them. Their terms of reference have been included as appendices:

- Health and Care Senate.
- Place based partnerships:
 - Bedford Borough Health and Wellbeing Board and Bedford Borough Place Executive Delivery Group.
 - Central Bedfordshire Place Board.
 - Luton At Place Board.
 - Milton Keynes Health and Care Partnership.

3.0 Scheme of Reservation and Delegation

3.1 The ICB has agreed a Scheme of Reservation and Delegation which sets out where functions and decisions are made and the delegated limits of financial authority.

3.2 The Scheme of Reservation and Delegation sets out those decisions that are reserved to the Board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The Scheme of Reservation and Delegation identifies where and to whom functions and decisions have been delegated.

3.3 The Scheme of Reservation and Delegation is set out at Appendix O.

4.0 Standing Financial Instructions

- 4.1 The ICB has agreed a set of Standing Financial Instructions which set out the arrangements for managing the ICB's financial affairs.
- 4.2 The Standing Financial Instructions are set out at Appendix P.

5.0 Functions and Decision Map

- 5.1 The Functions and Decision Map set out at Appendix Q is a high-level diagram to help stakeholders understand where decisions are made and is:
 - Locally defined.
 - Sets out where decisions are taken and outline the roles of different committees / partnerships.
 - Easily understood by the public.

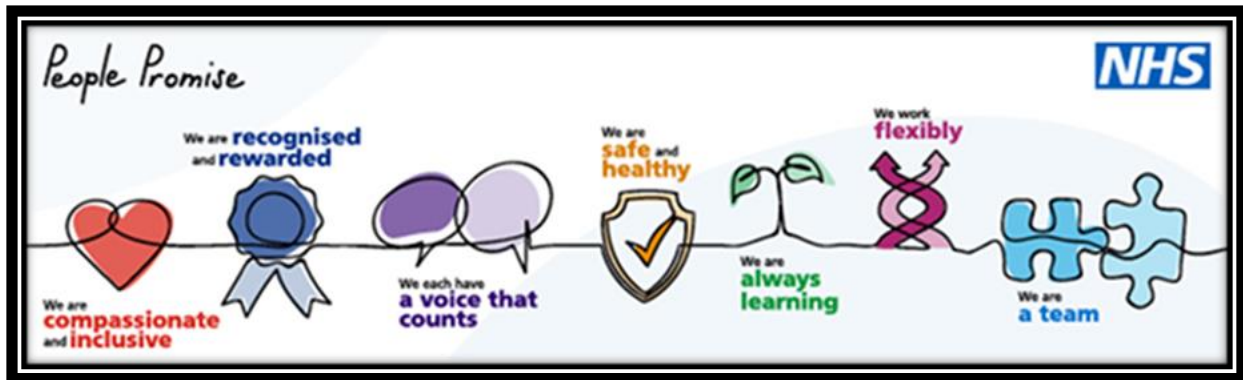
6.0 Core Responsibilities of the Board, its Committees and Sub-Committees, including Joint Committees and Consultative Forums

6.1 Integrated Care System Aims

- 6.1.1 All members and attendees of the Board, its committees and sub-committees, including joint committees and consultative forums are required to promote the four core aims of an integrated care system when making decisions.
- 6.1.2 The four core aims are to:
 1. **Improve outcomes** in population health and healthcare.
 2. **Tackle inequalities** in outcomes, experience and access.
 3. Enhance **productivity and value for money**.
 4. Help the NHS support broader **social and economic development**.

6.2 NHS People Plan and Promise

- 6.2.1 All members and attendees of the Board, its committees and sub-committees, including joint committees and consultative forums are required to follow the ambitions and actions set out in the NHS People Plan and Promise and be cognisant of the ICB's own People Plan when making decisions.
- 6.2.2 The annual NHS Staff Survey is constructed to measure the elements of the NHS People Plan.
- 6.2.3 The People Promise outlines behaviours and actions that staff can expect from NHS leaders and colleagues, to improve the experience of working in the NHS for everyone.



6.3 Bedfordshire, Luton and Milton Keynes Green Plan

6.3.1 All members and attendees of the Board, its committees and sub-committees, including joint committees and consultative forums are required to follow the Commitments set out in the Bedfordshire, Luton and Milton Keynes Green Plan and be cognisant of the ICB's own contribution to the Integrated Care System's Green Plan when making decisions.

6.3.2 The Bedfordshire, Luton and Milton Keynes Green Plan enables different partners to work collaboratively to reach net-zero emissions and manage their common resources more sustainably. Key targets include but are not limited to:

- Embedding environmental sustainability in workforce training.
- Increasing the uptake of greener modes of transport.
- Improving energy efficiency in estates and facilities.
- Reducing the over-prescription of medicines and single-use plastic items.
- Cutting down food waste and providing more sustainable food choices.
- Implementing sustainability requirements when choosing supply chain providers, and,
- Developing risk mitigation strategies for extreme weather events.

6.4 A new approach to Health and Care Professional Leadership

6.4.1 The ICB has adopted the following five core principles for effective clinical and care professional leadership, which are outlined below:

1. Integrating health and care professionals in decision-making at every level of the Integrated Care System.
2. Creating a culture of shared learning, collaboration and innovation, working alongside patients and local communities.
3. Ensuring our health and care professional leaders have appropriate resources to carry out their system role(s).
4. Identifying, recruiting and creating a pipeline of health and care professional leaders.
5. Providing dedicated leadership development for all health and care professionals.

6.5 Bedfordshire, Luton and Milton Keynes Working with People and Communities

6.5.1 All members and attendees of the Board, its committees and sub-committees, including joint committees and consultative forums are required to follow the principles set out in the Bedfordshire, Luton and Milton Keynes Working with People and Communities policy and be cognisant of the ICB's statutory duty to involve local people when making decisions.

6.5.2 The Bedfordshire, Luton and Milton Keynes Working With People and Communities policy enables and supports partners in working with communities to tackle health inequalities, include seldom heard voices in decision-making and break down barriers to local people accessing health and care in their area. Principles include:

- Using insights and lived experiences to inform strategy and design services.
- Engage residents in discussions about their local health and care services to support meaningful engagement.
- Work with trusted people to establish trust and break down barriers.
- Go to where people are to engage to ensure we hear representative and diverse views.
- Collaborate with partners to develop a shared understanding of our communities and build on best practice.
- Engage, communicate, listen and share information with residents, as part of a spectrum of involvement to build trust and deepen relationships.
- Feedback and show residents where their contribution has made a difference.
- Work with residents to co-produce where appropriate.

6.5.3 The Healthwatch organisations in Bedfordshire, Luton and Milton Keynes have jointly nominated an individual as a participant member of the Integrated Care Board.

6.5.4 The Integrated Care Board will publish the agendas, papers and minutes of its meetings held in public on its website. Members of the public will also be able to attend meetings held in public and to submit questions to the Board in advance of meetings as the discretion of the Chair.

6.6 Bedfordshire, Luton and Milton Keynes Health and Care Partnership Working with the Voluntary, Community and Social Enterprise Sector

6.6.1 Bedfordshire, Luton and Milton Keynes Health and Care Partnership recognises the value in developing an equal strategic partnership with the voluntary, community and social enterprise (VCSE) sector. This sector brings specialist expertise and fresh perspectives to public service delivery. It has a long track record in promoting engagement and finding creative ways to improve outcomes for groups with the poorest health, making it an essential partner in addressing health inequalities.

- 6.6.2 Bedfordshire, Luton and Milton Keynes Health and Care Partnership is committed to formalising a strategic partnership with the voluntary, community and social enterprise sector, building on existing structures and engagement at neighbourhood, place and system. A voluntary, community and social enterprise sector partnership forum is being developed through the established Bedfordshire, Luton and Milton Keynes Voluntary, Community and Social Enterprise Strategy Group. This group acts as a conduit to engage the sector more widely and ensures voluntary, community and social enterprise sector partners are embedded at all levels of governance and decision making across the system. The Bedfordshire, Luton and Milton Keynes Voluntary, Community and Social Enterprise Partnership Lead is a member of the of the Health and Care Partnership Joint Committee.
- 6.6.3 The Voluntary, Community and Social Enterprise Strategy Group has formally established a Memorandum of Understanding with the emerging partnership forum (our term for a Voluntary, Community and Social Enterprise sector alliance) in November 2022. The Memorandum establishes an adaptable and flexible framework that supports a culture of learning. It demonstrates shared vision and values and reiterates our ambition to put people in our communities at the heart of everything we do. The Memorandum builds on existing partnership working and dynamic relationships and helps guide decision making about how resources will be committed to support integrated working with voluntary, community and social enterprise sector partners to achieve our collective aims and objectives as equal partners.

7.0 System Oversight and Assurance

- 7.1 The ICB will work in partnership with NHS England to co-produce an approach to system oversight and assurance in line with the national frameworks prescribed by NHS England.
- 7.2 The BLMK Chief Executive Officers' Group fulfils this function, to ensure collective delivery through partners holding each other to account for the management of system resources and performance across the Integrated Care System.

8.0 Key Policies of the Integrated Care Board

- 8.1 The Integrated Care Board has identified the following as key policies. All members and attendees of the Board, its committees and sub-committees are required to adhere to these policies. The policies may be accessed directly from here:

<https://bedfordshirelutonandmiltonkeynes.icb.nhs.uk/>

8.2 Conflict of Interest Management and Standards of Business Conduct

- 8.2.1 The ICB has a policy setting out the arrangements in place for the conflict of interest management and the standards of business conduct expected by employees and workers within the ICB.

8.3 Working with People and Communities Policy

8.3.1 The Integrated Care Board has a policy setting out the ICB's approach to working with people and communities.

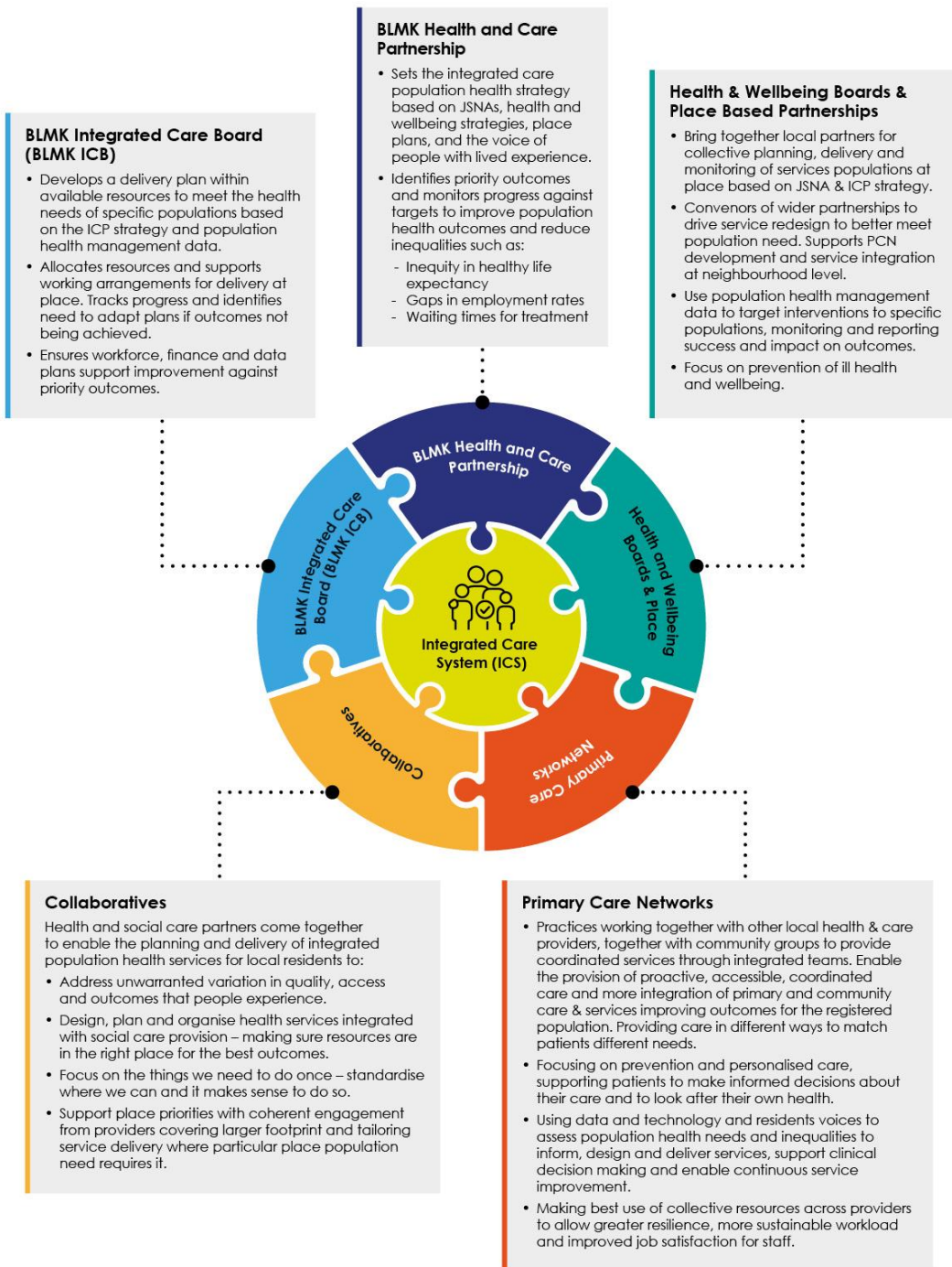
8.4 Risk Management Framework and Policy

8.4.1 The Integrated Care Board has a risk management framework and policy.

9.0 New Roles - in the Integrated Care System

9.1 The following diagram details the roles and responsibilities of the Integrated Care System, including the Health and Care Partnership (Joint Committee), the Integrated Care Board, the Health and Wellbeing Boards and Place based partnerships, primary care networks and collaboratives including the Bedfordshire Care Alliance.

New roles in the ICS



Appendix A – Audit and Risk Assurance Committee Terms of Reference

1.0 Constitution

- 1.1 The Audit and Risk Assurance Committee (the Committee) is established by the Integrated Care Board (ICB) as a committee of the Board of the ICB (the Board) in accordance with its Constitution.
- 1.2 These Terms of Reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.
- 1.3 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2.0 Authority

- 2.1 The Audit and Risk Assurance Committee is authorised by the Board to:
 - Investigate any activity within its terms of reference.
 - Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these Terms of Reference.
 - Commission any reports it deems necessary to help fulfil its obligations.
 - Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.
 - Create task and finish sub-groups to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and Terms of Reference of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation, but may not delegate any decisions to such groups.
- 2.2 For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation

3.0 Purpose

- 3.1 To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB and within the wider Bedfordshire, Luton and Milton Keynes system, such that the Committee can provide assurance to the Board that its objectives are likely to be met and risks are effectively managed. The Committee will meet in two parts as follows:

- 3.1.1 Part 1: to deal with internal ICB audit and risk business.
Part 2: to deal with system risk business, taking an overview of all system risks and having a particular deep dive focus on either the Bedfordshire or Milton Keynes health economies at alternate meetings.
- 3.1.2 The membership of the Committee will be structured to reflect the Part 1 and Part 2 business.
- 3.2 The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.
- 3.3 The Committee has no executive powers, other than those delegated in the Scheme of Reservation and Delegation and specified in these Terms of Reference.

4.0 Membership and attendance

Membership

- 4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.
- 4.2 The Board will appoint three members of the Committee who are independent non-executive members of the Board and members of both the Part 1 and Part 2 meetings of the Committee:
- 4.3 Neither the Chair of the Board, nor employees of the ICB will be members of the Committee.
- 4.4 Members will possess between them knowledge, skills and experience in: accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to equality and diversity.

Attendees

- 4.5 The Committee may also have regular attendees who will receive advanced copies of the notice, agenda, and papers for meetings. They may be invited to attend any or all the meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote. Regular attendees will include the following.
- Chief Finance Officer or their nominated deputy.
 - Chief of Strategy and Assurance or their nominated deputy.
 - Senior Information Risk Owner.
 - Caldicott Guardian.

- Accountable Emergency Officer.
 - Individuals who lead on risk management and counter fraud matters.
 - Representatives of both internal and external Audit.
- 4.6 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.
- 4.7 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any matter.
- 4.8 The Chief Executive should be invited to attend the meeting at least annually when the Annual Report and Accounts are being considered.
- 4.9 The Chair of the ICB may also be invited to attend to gain an understanding of the Committee's operations.

Part 2 Meeting Attendees:

- 4.10 The following will be invited to attend the Part 2 meeting of the Committee to enable the Committee to consider system risks:
- 4.10.1 NHS trust audit committee chairs and executive directors / senior council officers with responsibility for strategic risk management from all of the NHS trusts / foundation trusts and all of the local authorities in either the Bedfordshire or Milton Keynes health and care economies. The Committee will invite representatives from system partners and other non-executive members from the Board of the Integrated Care Board, as relevant to the agenda.

Chair and Deputy Chair

- 4.11 In accordance with the Constitution, the Committee will be chaired by an independent non-executive member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.
- 4.12 Committee members may appoint a Deputy Chair from amongst its members.
- 4.13 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

Attendance

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

Access

- 4.15 Regardless of attendance, external audit, internal audit and local counter fraud will have full and unrestricted rights of access to the members of the Audit and Risk Assurance Committee.

5.0 Meeting Quoracy and Decisions

- 5.1 The Committee will meet at least four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.
- 5.2 The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss issues on which they want the Committee's advice.
- 5.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

- 5.4 For a meeting to be quorate a minimum of two independent Non-Executive Members of the Board are required.
- 5.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.
- 5.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

- 5.7 Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach decisions by consensus. When this is not possible the Chair may call a vote.
- 5.8 Only members of the Committee may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter.
- 5.9 Where there is no clear majority, the Chair of the Committee will hold the casting vote.
- 5.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication.

6.0 Responsibilities of the Committee

- 6.1 The Committee's duties can be categorised as follows.

Part 1 Meeting

Integrated Governance, Risk Management and Internal Control

- 6.2 To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board.
- 6.3 To ensure that financial systems and governance are established which facilitate compliance with Department of Health and Social Care's Group Accounting Manual.
- 6.4 To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives and the effectiveness of the management of principal risks.
- 6.5 To have oversight of system risks where they relate to the achievement of the ICB's objectives.
- 6.6 To ensure that the ICB acts consistently with the principles and guidance established in HM Treasury's 'Managing Public Money' guidance¹.
- 6.7 To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
- 6.8 To identify opportunities to improve governance, risk management and internal control processes across the ICB.
- 6.9 To review any failures to comply with the standing orders or temporary suspension of the standing orders.

Internal Audit

- 6.10 To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:
 - Considering the provision of the internal audit service and the associated remuneration fee following recommendation of 'market value' by the Chief Finance Officer.
 - Reviewing and approving the annual Internal Audit Plan and more detailed programmes of work, ensuring that these are consistent with the audit needs of the organisation as identified in the Board Assurance Framework.
 - Considering the major findings of internal audit work, including the Head of

¹ <https://www.gov.uk/government/publications/managing-public-money>

Internal Audit Opinion (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources.

- Ensuring that the internal audit function is adequately resourced by management, and has appropriate standing within the organisation; and
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit

6.11 To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Deciding the appointment of the external auditors, as far as the rules governing the appointment permit, and considering their performance.
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee; and
- Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Agreeing the external auditor fee following recommendation of 'market value' by the Chief Finance Officer.

Other assurance functions

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

6.13 To review the work of other committees in the ICB, whose work can provide relevant assurance to the Audit and Risk Assurance Committee's own areas of responsibility.

6.14 To review the assurance processes in place in relation to key financial controls across the ICB including the completeness and accuracy of information provided.

6.15 To review the findings of external bodies and consider the implications for governance of the ICB.

Counter Fraud

- 6.16 To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's Standards and reviewing the outcomes of work in these areas.
- 6.17 To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitoring the implementation of action plans, providing direct access and liaison with those responsible for counter fraud, reviewing annual reports on counter fraud, and discussing NHS Counter Fraud Authority's quality assessment reports.
- 6.18 To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.
- 6.19 To be responsible for ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Standards for Commissioners: Fraud, Bribery and Corruption².
- 6.20 To report concerns of suspected fraud, bribery and corruption to the NHS Counter Fraud Authority.

Freedom To Speak Up

- 6.21 To review the adequacy and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters.
The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

Information Governance

- 6.22 To receive regular updates on information governance compliance (including uptake and completion of data security training), data breaches and any related issues and risks.
- 6.23 To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security and Protection Toolkit and relevant reports and action plans.
- 6.24 To receive reports on audits to assess information and Information Technology security arrangements, including the annual Data Security and Protection Toolkit audit.

² https://cfa.nhs.uk/resources/downloads/standards/NHS_Fraud_Standards_for_Commissioners_2020_v1.2.pdf

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

Financial reporting

- 6.26 To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.
- 6.27 To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.
- 6.28 To review the annual report and financial statements (including accounting policies) before submission to the Board focusing particularly on:
- The wording in the Governance Statement and other disclosures relevant to the terms of reference of the Committee.
 - Changes in accounting policies, practices and estimation techniques.
 - Unadjusted misstatements in the Financial Statements.
 - Significant judgements and estimates made in preparing of the Financial Statements.
 - Significant adjustments resulting from the audit.
 - Letter of representation; and
 - Qualitative aspects of financial reporting.

Emergency Preparedness, Resilience and Response (EPRR)

- 6.29 The Chair of the Audit and Risk Assurance Committee will be the nominated non-executive member for EPRR.
- 6.30 The Committee shall satisfy itself on behalf of the ICB that the appropriate governance and EPRR management processes are in place to enable the ICB to discharge its category 1 responsibilities for the system³. The Accountable Emergency Officer will provide an annual assurance report to the Board on this matter.

Conflicts of Interest

- 6.31 The Chair of the Audit and Risk Assurance Committee will be the nominated Conflicts of Interest Guardian.
- 6.32 The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

Management

³ https://www.england.nhs.uk/wp-content/uploads/2022/07/B0900_emergency-preparedness-resilience-and-response-framework.pdf

- 6.33 To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- 6.34 The Committee may also request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.
- 6.35 To receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of the ICB's Standing Orders, in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

Communication

- 6.36 To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.
- 6.37 To develop an approach with other committees, including the Integrated Care Partnership, to ensure the relationship between them is understood.

Part 2 Meeting

- 6.38 Part 2 of the Committee's business is focused on the effective management of system risk.
- 6.39 At each meeting, the Committee will review the Bedfordshire, Luton and Milton Keynes Integrated Care System Strategic Risk Register to review the adequacy and effectiveness of the system of risk management across the whole of the ICS's activities that support the achievement of the four core purposes of the ICS to:
- Improve outcomes in population health and healthcare.
 - Tackle inequalities in outcomes, experience and access.
 - Enhance productivity and value for money.
 - Help the NHS support broader social economic development.
- 6.40 The Committee will also review the risks to the delivery of the Integrated Care Partnership's 5-year population health management strategy and the ICB's 5-year strategic delivery plan and to highlight any areas of weakness to the Board and to the appropriate governance forums of Integrated Care System partners. Each Part 2 meeting will include a deep dive discussion with representatives of the partners from either the Bedfordshire or Milton Keynes health economies to support an informed discussion of system risk and the agreement of appropriate mitigation.

7.0 Behaviours and Conduct

ICB Values

- 7.1 Members will be expected to conduct business in line with the ICB values and objectives, and the principles set out by the ICB.
- 7.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and the Conflict of Interest Management and Standards of Business Conduct Policy.

Equality and Diversity

- 7.3 Members must consider the equality and diversity implications of decisions they make.

8.0 Accountability and reporting

- 8.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities. It shall provide reports to partners on its Part 2 business in relation to system risk management, as required.
- 8.2 The minutes of the meetings shall be formally recorded by the secretary in accordance with the Standing Orders.
- 8.3 The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.
- 8.4 The Chair of the Committee will provide the Board with an independent annual report, timed to support finalisation of the accounts and the Governance Statement. The report will summarise its conclusions from the work it has done during the year specifically commenting on:
 - The fitness for purpose of the Board Assurance Framework.
 - The completeness and 'embeddedness' of risk management in the organisation.
 - The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements.
 - The effectiveness of the management of system risks.

9.0 Secretariat and Administration

- 9.1 The Committee shall be supported with a secretariat function which will include ensuring that:
 - The agenda and papers are prepared and distributed at least five working days before each meeting in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Executive lead.
 - Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not attend at least 75% of meetings..

- Records of members' appointments and renewal dates are reviewed and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues / areas of interest / policy developments.
- Action points are taken forward between meetings and progress against those actions is proactively monitored.

10.0 Review

10.1 The Committee will review its effectiveness at least annually.

10.2 These Terms of Reference will be reviewed at least every two years and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

Appendix B – Quality and Performance Committee Terms of Reference

1.0 Constitution

- 1.1 The Quality and Performance Committee (the Committee) is established by the Integrated Care Board (ICB) as a committee of the Board of the ICB (the Board) in accordance with its Constitution.
- 1.2 These Terms of Reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.
- 1.3 The Committee is a non-executive chaired committee of the Board, and its members are bound by the Standing Orders and other policies of the ICB.

2.0 Authority

- 2.1 The Quality and Performance Committee is authorised by the Board to:
 - Investigate any activity within its Terms of Reference.
 - Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these Terms of Reference.
 - Commission any reports it deems necessary to help fulfil its obligations.
 - Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.
 - Create task and finish sub-groups to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and Terms of Reference of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation, but may not delegate any decisions to such groups.

3.0 Purpose

- 3.1 The Quality and Performance Committee has been established to provide the ICB with assurance that it is delivering its functions in relation to the Bedfordshire Luton and Milton Keynes system in a way that secures continuous improvement in the quality and effectiveness of services provided to the population of Bedfordshire Luton and Milton Keynes, against each of the dimensions of quality set out in the NHS Quality Board: Shared Commitment to Quality⁴ (safe, effective, positive experience, well-led, equitable and sustainably resourced) and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care.

⁴ <https://www.england.nhs.uk/publication/national-quality-board-shared-commitment-to-quality/>

- 3.2 The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and system performance management that supports it to effectively deliver its strategic objectives and ensure that sustainable, high quality care is provided to its population.
- 3.3 The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

4.0 Membership and attendance

- 4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.
- 4.2 The Board will appoint seven members of the Committee including three who are independent non-executive members of the Board.

Members

- Non-executive member (Chair).
- Two non-executive members
- Chief Nurse.
- Chief Medical Director.
- Chief of Strategy and Assurance.
- Chief People Officer.
- One primary medical services partner member who is a health care professional (Deputy Chair).
- A Member from the Integrated Care Board Health and Care Senate.

Regular Attendees

- 4.2.1 The Committee may also have regular attendees who are not drawn from the Integrated Care Board. Attendees will receive advanced copies of the notice, agenda, and papers for meetings. They may be invited to attend any or all the meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote. The following will be invited to be regular attendees:
- Director-level representatives who are able to take a system view of performance and quality risks from the alliances, places and local authorities in the system.
- 4.2.2 Quality committee chairs from BLMK's NHS trusts / foundation trusts and local authority directors with responsibility for quality of adults and children's services may be invited by the Chair of the Committee to attend meetings of the committee as relevant to the agenda.
- 4.3 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

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

Chair and Deputy Chair

- 4.5 The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.
- 4.6 If a Chair has a conflict of interest, then the Deputy Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

Attendees

- 4.7 The Committee may also invite other system colleagues to attend any or all the meetings, or part(s) of a meeting for specific agenda items. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote:

5.0 Meeting Quoracy and Decisions

- 5.1 The Committee will meet at least four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

Quorum

- 5.2 There will be a minimum of two non-executive member, plus at least either the Chief Nurse or Chief Medical Director and a one other member.
- 5.3 Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.

Decision making and voting

- 5.4 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach decisions by consensus. When this is not possible the Chair may call a vote.
- 5.5 Only members of the Committee may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter.
- 5.6 Where there is no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.
- 5.7 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication.

6.0 Responsibilities of the Committee

6.1 The responsibilities of the Quality and Performance Committee will be authorised by the Board of the ICB. The Quality and Performance Committee will develop an approach to assurance in partnership with NHS Trusts and Foundation Trusts, primary care providers, and other health and care providers operating within BLMK, which may include seeking assurance through participating in Trust assurance and governance processes to avoid creating unnecessary duplication of work (embedded assurance).

6.2 In line with the Care Quality Commission's quality statement themes and dimensions of quality prescribed by the NHS Quality Board, the Quality and Performance Committee will carry out the following responsibilities:

6.3 Leadership

6.3.1 Agree the **key quality priorities** that are included within the ICB strategy / operating plan, including priorities to address variation / inequalities in care. Ensuring shared direction and culture in order to achieve positive outcomes that reflect partnerships and communities and awareness of environmental sustainability.

6.3.2 Agree and oversee implementation of a framework and process **of equality impact assessments** and **quality impact assessments** for system-wide oversight of any significant service and policy changes and pathways redesigns and advise the Board on these matters from a quality, performance, and equality perspective.

6.3.3 Ensure effective governance and assurance in relation to risks.

6.3.4 Be assured that the system's five year and one-year operational delivery plans (including any associated transformation and efficiency programmes) deliver the **required outcomes** and ensure that high quality care is maintained, and **equality** is advanced via oversight of the ICB's **equality impact assessment** and **quality impact assessment** process reporting any significant risks and mitigation plans to the Committee.

6.3.5 Have oversight of and approve the Terms of Reference and work programmes for the task and finish groups reporting into and/or supporting the work of the Quality and Performance Committee.

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

6.3.7 Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) **directives, regulations, national standards, policies, reports, reviews and best practice** as issued by the Department of Health and Social Care, NHS England and other regulatory bodies / external agencies (e.g.,

Care Quality Commission, National Institute for Health and Care Excellence) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.

- 6.3.8 Agree and monitor delivery of remedial action plans in respect of **significant system performance issues** and escalate to the Board of the Integrated Care Board as appropriate.
- 6.3.9 Maintain an overview of changes in the methodology employed by regulators and **changes in legislation / regulation** and assure the Board of the ICB that these are disseminated and implemented at a system-level and across NHS Trusts/Foundation Trusts within the system.
- 6.3.10 Oversee and seek assurance on the effective and sustained delivery of the **ICB Quality Improvement Programmes**. Ensuring demonstration of learning improvement, innovation led by capable, compassionate, and inclusive leaders within all programmes.
- 6.3.11 Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place including **performance against local and national, including regulatory and NHS Constitution standards**.

6.4 Quality and Safety

- 6.4.1 Oversee and monitor delivery of the ICB key **statutory requirements** in relation to performance and quality and assure the quality, safety and effectiveness of commissioned services. To include oversight of workforce and safe staffing.
- 6.4.2 Receive assurance that the ICB identifies system-level **lessons learned** from all relevant sources, including, **incidents, never events, complaints and claims** and ensures that learning is disseminated and embedded and that appropriate mechanisms are operating within NHS trusts/foundation trusts within the system. Clearly identifying a **learning culture** within system partners.
- 6.4.3 To be assured that **people drawing on services** are systematically and effectively involved as **equal partners** enabling individuals to live healthier lives and participate in quality activities at a system-level and by NHS Trusts / Foundation Trusts within the system.
- 6.4.4 Monitor 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 and ensure that strategies to reduce inequality in the population are developed and implemented, ensuring equity in access experience and outcomes.
- 6.4.5 Monitor and respond to the priorities and outcomes of local safeguarding arrangements to assure compliance with the ICB's statutory responsibilities for **safeguarding adults and children**.

- 6.4.6 Receive assurance that the ICB has effective and transparent mechanisms in place to **monitor mortality** at a system-level and that it learns from death (including coronial inquests and Prevention of Future Deaths reports) and that appropriate mechanisms are operating within NHS trusts / foundation trusts within the system.
- 6.4.7 Monitor the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for **medicines optimisation and safety**.
- 6.4.8 Monitor the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for **infection prevention and control**.
- 6.4.9 To receive an annual report from the Exceptional Cases Panel covering the number of cases considered, case outcomes, alongside any issues and risks arising.

6.5 Integration

- 6.5.1 Be assured that there are robust processes in place for the effective **management of quality and performance** at a system-level and within NHS trusts / foundation trusts within the system.
- 6.5.2 Scrutinise structures in place to support **quality planning, control and improvement**, to be assured that the structures operate effectively, and timely action is taken to address areas of concern at a system-level and within NHS trusts / foundation trusts within the system.
- 6.5.3 Identify how services and teams work together to ensure pathways and transitions of care, care provision, integration and continuity are effective and safe with **good patient outcomes**.

6.6 Individual Funding Requests

- 6.6.1 Approve arrangements for managing Individual Funding Requests.

7.0 Behaviours and Conduct

ICB Values

- 7.1 Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Conflicts of Interest Management and Standards of Business Conduct Policy.

Equality and Diversity

- 7.2 Members must promote and consider the equality and diversity implications of decisions they make.

Declarations of Interest

- 7.3 All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

8.0 Accountability and reporting

- 8.1 The Quality and Performance Committee is directly accountable to the Board of the ICB. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board (public session) after each meeting and provide a report on assurances received, escalating any concerns where necessary.
- 8.2 The Committee will advise the Audit and Risk Assurance Committee on the adequacy of assurances available and contribute to the Governance Statement.
- 8.3 The Committee will receive scheduled assurance reports from its delegated groups and partners with statutory responsibilities for health and social care provision in Bedfordshire, Luton and Milton Keynes. Any delegated groups would need to be agreed by the Board of the ICB.
- 8.4 The Chief Nurse will report on any issues arising from meetings of the System Quality Group.

9.0 Secretariat and Administration

- 9.1 The Committee shall be supported with a secretariat function which will include ensuring that:
- The agenda and papers are prepared and distributed at least five working days before each meeting in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Executive lead.
 - Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not attend at least 75% of meetings..
 - Records of members' appointments and renewal dates are reviewed and the Board is prompted to renew membership and identify new members where necessary.
 - Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
 - The Chair is supported to prepare and deliver reports to the Board.
 - The Committee is updated on pertinent issues / areas of interest / policy developments.
 - Action points are taken forward between meetings and progress against those actions is proactively monitored.

10.0 Review

- 10.1 The Committee will review its effectiveness at least annually.
- 10.2 These Terms of Reference will be reviewed at least every two years and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

Appendix C – Remuneration Committee Terms of Reference

1.0 Constitution

- 1.1 The Remuneration Committee (the Committee) is established by the Integrated Care Board (ICB) as a committee of the Board of the ICB (the Board) in accordance with its Constitution.
- 1.2 These Terms of Reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.
- 1.3 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2.0 Authority

- 2.1 The Committee is authorised by the Board to:
 - Investigate any activity within its Terms of Reference.
 - Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these Terms of Reference.
 - Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.
 - Create task and finish groups to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and Terms of Reference of any such task and finish groups in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation but may not delegate any decision making powers to such groups.
- 2.2 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these Terms of Reference other than the Committee being permitted to meet in private.

3.0 Purpose

- 3.1 The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary:
 - Confirm the ICB Remuneration Policy including adoption of any pay frameworks for all employees including senior managers / Directors (including Board members).

4.0 Membership and attendance

Membership

- 4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.
- 4.2 The Board will appoint five members of the Committee who are independent non-executive members of the Board (including the Chair of the ICB).
- 4.3 When determining the membership of the Committee, active consideration will be made to equality and diversity.

Chair and Deputy Chair

- 4.4 In accordance with the Constitution, the Committee will be chaired by an independent non-executive member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.
- 4.5 Committee members may appoint a Deputy Chair from amongst its members.
- 4.6 In the absence of the Chair, or Deputy Chair, the remaining members present shall elect one of their number to chair the meeting.
- 4.7 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

Attendees

- 4.8 The Committee may also have regular attendees who are not drawn from the Integrated Care Board. Attendees will receive advanced copies of the notice, agenda, and relevant papers for meetings. They may be invited to attend any or all the meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote. Regular attendees will include the following.:
 - Chief Executive or their nominated deputy.
 - Chief People Officer or their nominated deputy.
 - Head of Governance or their nominated deputy.
- 4.9 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.
- 4.10 No individual should be present during any discussion relating to:
 - Any aspect of their own remuneration.
 - Any aspect of the remuneration of others when it has an impact on them.
- 4.11 The Remuneration Committee will not consider any matters relating to the remuneration of non-executive members due to a conflict of direct financial

interest.

- 4.12 Any remuneration proposed which is outside the national pay framework for non-executive members will be considered instead by a Special Remuneration Panel.

5.0 Meeting Quoracy and Decisions

- 5.1 The Committee will meet in private.
- 5.2 The Committee will meet at least four times a year in its first year then thereafter at least twice a year, and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.
- 5.3 The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss issues on which they want the Committee's advice.
- 5.4 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

- 5.5 For a meeting to be quorate a minimum of two independent non-executive members of the Board are required.
- 5.6 If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.
- 5.7 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

- 5.8 Decisions will be guided by national NHS policy and best practice to ensure that staff are motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.
- 5.9 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
- 5.10 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.11 Where there no clear majority, the Chair of the Committee will hold the casting vote.

6.0 Responsibilities of the Committee

6.1 The Committee's duties are as follows:

6.2 For the Board of the ICB

- Talent and succession planning.

6.3 For the Chief Executive, directors and other very senior managers:

- Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, implementation of national pay awards, pensions and cars.
- Determine arrangements for termination of employment and other contractual terms and non-contractual terms.
- Set the framework for and assuring the completion of performance review/s of the senior executive team in line with regional and national guidance.

6.4 For all employees and workers:

- Determine the ICB remuneration policy (including the adoption of pay frameworks such as Agenda for Change).
- Oversee contractual arrangements.
- Approve termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.
- Assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including, for example, the Fit and Proper Persons regulation⁵.

6.5 The Committee will take proper account of national agreements and appropriate benchmarking, for example, Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

7.0 Behaviours and Conduct

ICB Values

7.2 Members will be expected to conduct business in line with the ICB values and objectives, and the principles set out by the ICB.

⁵ Regulation 5, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

Equality and Diversity

- 7.4 Members must consider the equality and diversity implications of decisions they make.

8.0 Accountability and reporting

- 8.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.
- 8.2 The minutes of the meetings shall be formally recorded by the secretary.
- 8.3 The Committee Chair will provide assurance reports to the Board following each meeting of the Committee. Where minutes and reports identify individuals, they will not be made public and will be presented at a private session of the Board. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.
- 8.4 The Chair of the Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

9.0 Secretariat and Administration

- 9.1 The Committee shall be supported with a secretariat function which will include ensuring that:
- The agenda and papers are prepared and distributed at least five working days before each meeting in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Executive lead.
 - Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not attend at least 75% of meetings..
 - Records of members' appointments and renewal dates are reviewed and the Board is prompted to renew membership and identify new members where necessary.
 - Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
 - The Chair is supported to prepare and deliver reports to the Board.
 - The Committee is updated on pertinent issues / areas of interest / policy developments.
 - Action points are taken forward between meetings and progress against those actions is proactively monitored.

10.0 Review

- 10.1 The Committee will review its effectiveness at least annually.
- 10.2 These Terms of Reference will be reviewed at least every two years and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

Appendix D – Bedfordshire Care Alliance Committee Terms of Reference

1.0 Introduction and Role of the Committee

- 1.1 Members of the Bedfordshire Care Alliance Committee (“BCA Committee”) will come together as a committee of the Board of the Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB) to enable the planning and delivery of integrated population health services for the residents of Bedfordshire focussing on quality improvement and best value. The terms of reference of this Committee have been approved by the Board of BLMK ICB.
- 1.2 The BCA Committee will be responsible for making decisions on matters that it has been delegated to on behalf of the BLMK ICB or other constituent partner members of the BCA and these are described in the duties of the Committee at paragraph 9 below.
- 1.3 The overall aims of the Committee are to bring health and care partners across Bedfordshire together to work collaboratively and hold joint accountability for:
 - Addressing unwarranted variation in quality, access and outcomes that people experience in different parts of Bedfordshire.
 - Designing, planning and organising health services integrated with social care provision in Bedfordshire – making sure resources are in the right place for the best outcomes.
 - Focussing on the things we need to do once across Bedfordshire – standardise where we can, and it makes sense to do so.
 - Supporting place priorities with coherent engagement from providers covering a larger footprint and tailoring where particular place population need requires it.
- 1.4 Where decisions are taken under these Terms of Reference, these will reflect national priorities and strategies as well as the local integrated care strategy developed by the BLMK Integrated Care Partnership.
- 1.5 The Committee will evolve over time. The BCA Committee will develop during 2022/23 to take responsibility for more functions and matters on behalf of the ICB in line with its work plan. It will also oversee plans for the further development of the BCA. In the longer term, it is the intention to create a Bedfordshire provider collaborative with identified delegated functions and resources from the ICB. The aim is that this arrangement will be operational by April 2023 with some delegated functions and resources. It will necessitate changes in the way the Committee operates. For example, the Committee may take on an assurance role on behalf of the ICB to oversee the work of the provider collaborative.
- 1.6 The BCA Committee will operate within the BLMK ICB reporting to the ICB in relation to the exercise of its functions as set out at paragraph 9. These terms of reference will be reviewed during 2022/23 in line with the developing

national guidance and legislative framework of the Health and Care Act 2022 and changes in functions as set out above.

2.0 Membership

2.1 There will be a core membership of the Committee as set out below at paragraph 2.2. In addition, the BCA Committee may invite individuals, groups or subject matter experts to attend meetings, where this would assist it in its role and in the discharge of its duties but would not be members of the Committee. In the work of the BCA, there will need to be a wider range of providers, voluntary and community sector representatives as well as residents/public co- production and participation.

2.2 Committee Members (with voting rights)

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board	Non-executive member Chief Executive or nominated representative
Bedfordshire Hospitals NHS Foundation Trust	Chief Executive
Cambridgeshire Community Services NHS Trust	Chief Executive
East London NHS Foundation Trust	Chief Executive
Bedford Borough Council	One nominated officer
Central Bedfordshire Council	One nominated officer
Luton Borough Council	One nominated officer
Primary Care Networks	Nominated clinical leaders from Bedford, Luton and Central Bedfordshire

2.3 All Committee members will be able to nominate deputies to attend and vote on their behalf.

Attendees of the Committee (without voting rights):	ICB/BCA partner executives as relevant to support the work of the Board
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2.4 The membership of the BCA Committee will change over time as the work of the Committee develops. In any event the membership of the Committee will be reviewed every six months.

3.0 Chair

3.1 The BCA Chair will be the ICB non-executive member of the Committee. If the Chair of the Committee is absent, a chair for the meeting will be appointed by the members present.

4.0 Quorum

4.1 At least one member from the ICB and one member from each of the NHS provider organisations, one member from a local authority and one from a PCN must be present to make the meeting quorate.

4.2 No formal business shall be transacted where a quorum is not reached.

5.0 Frequency of meetings and attendance

5.1 A minimum of four scheduled meetings shall be held per year.

5.2 Members of the Committee should make every effort to attend all meetings of the Committee and there is an expectation that members should attend 75% of meetings as a minimum. The Secretary to the Committee will monitor attendance and will report on this annually. Attendance figures will be published in the ICB's Annual Report.

6.0 Meetings to be held in public

6.1 The ICB and committees are subject to the Public Bodies (Admission to Meetings) Act 1960. This legislation requires that all meetings at which the organisation exercises its statutory functions are held open to the public. Therefore, by default the BCA Committee should be held in public if exercising a statutory function. In this instance, the meeting may however pass a resolution to exclude the public from the meeting, or part of a meeting, if publicity would be prejudicial to the public interest due to the confidential nature of the business to be transacted or for other reasons stated in the resolution and arising from the nature of that business or of the proceedings.

6.2 In the first instance, it is not envisaged that the Committee will be exercising delegated statutory ICB functions, but this will be kept under review as the Committee develops.

7.0 Agenda setting

7.1 The agenda for BCA Committee meetings and informal workshops will be set by the BCA Committee agenda setting group comprising of:

- BCA Committee Chair
- BCA Executive Group Chair
- With the support of lead officers.

7.2 A forward plan of items for consideration will be included in the agenda papers for each BCA Committee meeting.

8.0 Decision Making and Voting

8.1 The Committee uses a collective model of decision-making that seeks to find consensus between partners and make decisions based on unanimity as the 'norm', including working through difficult issues where appropriate. Generally, it is expected that decisions of the Committee will be reached by consensus. Should this not be possible then a vote will be required.

- 8.2 Decisions will be taken in accordance with the Standing Orders. The BCA will ordinarily reach decisions by consensus. When this is not possible the Chair may call a vote.
- 8.3 Only members of the BCA Committee may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.
- 8.4 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication. Where any such action has been taken between meetings, then these will be reported to the next meeting.

9.0 Responsibilities of the Committee

- 9.1 The BCA Committee will seek to act in the best interest of patients and residents in the Bedfordshire health and care system, rather than representing the individual interests of any of its members.
- 9.2 The role of the BCA Committee, for those matters it is responsible for, is as follows:
- To oversee service and quality improvement, integration and delivery to meet the needs and expectations of patients and residents for their health services, improve outcome, reduce inequalities and ensure best use of resources.
 - To provide leadership for, and delivery of, for the population of Bedfordshire, the overarching strategy and outcomes framework set by the BLMK Integrated Care Partnership within the parameters delegated by the Board of the ICB.
 - To develop and oversee the delivery of the BCA's annual work plan.
 - To integrate physical and mental health services across the pathway around individuals and populations.
 - To use joined-up data, guidance and improvement frameworks to prioritise work, address variation and drive continuous improvement and track delivery.
 - To take a co-production approach to planning and delivery and ensure the views of residents, patients, users and carers are central to the work of the Committee.
 - To provide oversight and facilitation of the transformation and design of the health services in Bedfordshire integrated with social care.
 - To support and develop the workforce to deliver service transformation and integration.
 - To implement ICB strategies (e.g., digital) in a way that is locally sensitive for Bedfordshire.
 - To take collective decisions on the use of funding allocated to the BCA

Board from the Board of the BLMK ICB.

- To promote and model partnership working within the BCA.
- To lead Bedfordshire-wide action on data and digital, estates and workforce and supporting the ICB in enacting its system wide responsibilities for these enablers.
- To oversee the development of the BCA including agreeing the future development and transition plan to establish a lead provider or other arrangement in the future if deemed appropriate, including overseeing the due diligence process.
- To manage any actual or potential conflicts of interest, in accordance with applicable guidance and legal requirements including relevant ICB conflicts of interests and standards or business conduct policies.

10.0 Emergency powers

- 10.1 Where an urgent decision needs to be made in between scheduled meetings, members of the BCA Committee can convene an extra-ordinary meeting to discuss a particular issue. Quorum rules above still apply.
- 10.2 If it is not practicable to meet in person, matters can be dealt with through telephone or the exchange of emails. The exercise of such powers shall be reported, and a minute taken at the next Committee meeting.

11.0 Reporting arrangements to the ICB and partner organisations

- 11.1 The BCA Committee will report to the Board of the ICB and appropriate governance structures in partner organisations on a quarterly basis when the minutes of the BCA Committee meetings will be presented along with a summary report of business conducted including any recommendations/matters which require disclosure, escalation, action or approval.

12.0 Reporting arrangements of other Committees and Groups

- 12.1 The following groups will report into the BCA Committee and provide minutes of their meetings:
- BCA Executive Group
 - BCA Clinical and Professional Leadership Group.

13.0 Secretariat and Administration

- 13.1 The Committee shall be supported with a secretariat function which will include ensuring that:
- The agenda and papers are prepared and distributed at least five working days before each meeting in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
 - Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
 - Records of members' appointments and renewal dates and the Board is

prompted to renew membership and identify new members where necessary.

- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues / areas of interest / policy developments.
- Action points are taken forward between meetings and progress against those actions is proactively monitored.

14.0 Review

14.1 The Committee will review its effectiveness at least annually.

14.2 These Terms of Reference will be reviewed at least every two years and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

Appendix E – Finance and Investment Committee Terms of Reference

1.0 Constitution

- 1.1 The Finance and Investment Committee (the Committee) is established by the Integrated Care Board (ICB) as a committee of the Board of the ICB (the Board) in accordance with its Constitution.
- 1.2 These Terms of Reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.
- 1.3 The Committee is a non-executive chaired committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2.0 Authority

- 2.1 The Committee is authorised by the Board to:
 - Investigate any activity within its terms of reference.
 - Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference.
 - Commission any reports it deems necessary to help fulfil its obligations.
 - Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.
 - Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation but may not delegate any decisions to such groups.
- 2.2 For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation.

3.0 Purpose

- 3.1 To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan. This includes:
 - Financial performance of the ICB.
 - Financial performance of NHS organisations within the ICB footprint.

- 3.2 The Committee will meet in two parts, as follows.
Part 1: To deal with internal ICB financial and investment issues.
Part 2: To deal with the wider system financial landscape.
- 3.3 The Committee has no executive powers, other than those delegated in the Scheme of Reservation and Delegation and specified in these terms of reference.

4.0 Membership and attendance

Membership

- 4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.
- 4.2 The Board will appoint no fewer than four members of the Committee including at least three who are independent non-executive members of the Board. The Committee members will be
- Non-executive member (Chair).
 - Non-executive member (Deputy Chair).
 - Non-executive member
 - Chief Finance Officer.
 - Chief Medical Director.
 - Chief Nurse.
- 4.3 Members will possess between them knowledge, skills and experience in:
- Accounting.
 - Financial risk management.
 - Technical, commercial or specialist issues pertinent to the ICB's business.
 - Financial strategy and value for money
- 4.4 When determining the membership of the Committee, active consideration will be made to equality and diversity.
- 4.5 Additional attendees will be invited for part 2 of the meeting as relevant to the agenda, but may include the chief financial officers of NHS providers in BLMK.

Chair and Deputy Chair

- 4.5 In accordance with the Constitution, the Committee will be chaired by an independent non-executive member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.
- 4.6 Committee members may appoint a Deputy Chair from amongst its members.
- 4.7 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

4.8 Attendees non-voting

4.8.1 The following non-voting attendees will be invited to attend the meetings of the Finance and Investment Committee:

- Chief People Officer.
- Chief Operating Officer.
- Chief of Primary Care.

4.8.2 The Committee may also have regular attendees who are not drawn from the Integrated Care Board. Attendees may receive advanced copies of the notice, agenda, and papers for meetings as appropriate to the agenda items. They may be invited to attend any or all the meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote:

- Directors of Finance from NHS trusts / foundation trusts and local authorities in the Integrated Care System.
- Non-executive chairs of NHS trust / foundation trust finance committees or other non-executive directors nominated for this purpose by the trusts.
- Chief of Strategy and Assurance.
- ICB Head of Estates.
- ICB Chief Digital and Information Officer.

4.9 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters and/or to manage agenda item-specific conflicts of interest.

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

Attendance

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

5.0 Meeting Quoracy and Decisions

5.1 The Committee will meet at least four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

5.2 The Board, Chair or Chief Executive may ask the Finance and Investment Committee to convene further meetings to discuss issues on which they want the Committee's advice.

- 5.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

- 5.4 For a meeting to be quorate a minimum of 50% of the members are required, including one non-executive member.
- 5.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.
- 5.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

- 5.7 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach decisions by consensus. When this is not possible the Chair may call a vote.
- 5.8 Only members of the Committee may vote. Attendees are not entitled to vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there with no clear majority, the Chair of the Committee will hold the casting vote.
- 5.9 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication. Where any such action has been taken between meetings, then these will be reported to the next meeting.

6.0 Responsibilities of the Committee

- 6.1 The Committee's duties can be categorised as follows:

System financial management framework

- To shape the system's strategic financial framework and the system's medium term financial plan and monitor performance against it.
- To develop the system's and ICB's financial information systems and processes to be used to make recommendations to the Board on financial planning in line with the strategy and national guidance.
- To ensure health and social inequalities are considered in financial decision-making.

Resource allocations (revenue)

- To develop an approach to distribute the resource allocation through commissioning and direct allocation to drive agreed change based on the

Integrated Care Partnership's and ICB's strategies and to recommend revenue and capital budgets to the ICB.

- To advise on and oversee the process regarding the deployment of system-wide transformation funding.
- To take lead responsibility on behalf of the Board for the review of the system's long-term investment and dis-investment strategy and for recommending significant investment and dis-investment decisions to the Board in line with the delegated limits set out in the Standing Financial Instructions.
- To work with Integrated Care System partners to identify resources where appropriate to address finance and performance related issues that may arise.
- To work with Integrated Care System partners to consider major investment/disinvestment outlined in business cases for material service change or efficiency schemes and to agree a process for sign off including recommending significant business cases to the Board of the ICB.
- To approve contracts for commissioning support in line with the delegated limits set out in the Scheme of Reservation and Delegation.
- To recommend to the Board variations of budgets where that variation has a material impact.
- To recommend to the Board arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other clinical commissioning groups or pooled budget arrangements under section 75 of the NHS Act 2006).

National framework

- To advise the ICB 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.
- To oversee national ICB level financial submissions.
- To ensure the required preparatory work is scheduled to meet national planning timelines.

Financial monitoring information

- To develop a reporting framework for the ICB as a statutory body, using the chart of accounts devised by NHS England and the Integrated Single Financial Environment (ISFE) and the ICB as a system of bodies.
- To approve arrangements for the discharge of the ICB's statutory financial duties.
- To articulate the financial position and financial impacts (both short and long-term) to support decision-making.
- To work with Integrated Care System partners to identify and agree common approaches across the system such as financial reporting, estimates and judgements.

- To work with Integrated Care System 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 and Risk Assurance Committee)
- To oversee the development of financial and activity modelling to support the ICB priority areas.
- To develop a medium and long-term financial plan which demonstrated ongoing value and recovery.
- To develop an understanding of where costs sit across a system, system cost drivers and the impacts of service change on costs.
- To ensure appropriate information is available to manage financial issues, risks and opportunities across the ICB.
- To manage financial and associated risks by developing and monitoring a finance (and estates) risk register.

Performance

- To oversee the management and delivery of the system financial target and the ICB's own financial targets.
- To agree key outcomes to assess delivery of the ICB system financial strategy.
- To monitor and report to the Board overall financial performance against national and local Integrated Care System targets, highlighting areas of concern.
- To monitor and report to the Board key service performance which should be considered when assessing the financial position.

System efficiencies

- To ensure system efficiencies are identified and monitored across the system, pursuing opportunities at system level where the scale of the ICB partners together and the ability to work across organisations can be leveraged.
- To work with the Quality and Performance Committee and the Health and Care Senate to ensure that system efficiencies are designed to improve population health outcomes and that quality and quality impact assessments of system efficiencies are undertaken.
- To ensure financial resources are used in an efficient way to deliver the objectives of the Integrated Care System.
- To review exception reports on any material breaches of the delivery of agreed efficiency improvement plans including the adequacy of proposed remedial action plans

Communication

- To co-ordinate and manage communications on financial governance with stakeholders internally and externally.

- To develop an approach with partners, including the Bedfordshire, Luton and Milton Keynes Health and Care Partnership, to ensure the relationships between cost, performance, quality and environmental sustainability are understood.

People

- To develop a system finance staff development strategy, to ensure excellence by attracting and retaining the best finance talent.
- To ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements.

Capital (including estates and digital investment)

- Ratify proposals for the acquisition or disposal of property.
- To be advised by the Capital and Estates Oversight Group and System Finance Directors on the development of the system estates strategy and plan to ensure it properly balances clinical, strategic and affordability drivers and to recommend the system estates strategy to the Board of the ICB for approval.
- To monitor the system capital programme against the capital envelope and take action to ensure that it is appropriately and completely used.
- To gain assurance that the estates plan is built into system financial plans.
- To ensure effective oversight of future prioritisation and capital funding bids.

Other

- To approve banking arrangements
- To approve the agreement and monitoring of the annual Procurement Plan.

7.0 Behaviours and Conduct

ICB Values

- 7.1 Members will be expected to conduct business in line with the ICB values and objectives.
- 7.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Conflicts of Interest Management and Standards of Business Conduct Policy.

Conflicts of Interest

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

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

Equality and Diversity

- 7.5 Members must consider the equality and diversity implications of decisions they make.

8.0 Accountability and reporting

- 8.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.
- 8.2 The minutes of the meetings shall be formally recorded by the secretary in accordance with the Standing Orders.
- 8.3 The Chair will provide assurance reports to the Board after each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.
- 8.4 The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference, details on progress and a summary of key achievements in delivering its responsibilities.

9.0 Secretariat and Administration

- 9.1 The Committee shall be supported with a secretariat function which will include ensuring that:
- The agenda and papers are prepared and distributed at least five working days before each meeting in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Executive lead.
 - Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not attend at least 75% of meetings.
 - Records of members' appointments and renewal dates are reviewed and the Board is prompted to renew membership and identify new members where necessary.
 - Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
 - The Chair is supported to prepare and deliver reports to the Board.
 - The Committee is updated on pertinent issues / areas of interest / policy developments.
 - Action points are taken forward between meetings and progress against those actions is proactively monitored.

10.0 Review

- 10.1 The Committee will review its effectiveness at least annually.
- 10.2 These Terms of Reference will be reviewed at least every two years and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

Appendix F – Primary Care Commissioning and Assurance Committee Terms of Reference

1.0 Constitution

- 1.1 The Primary Care Commissioning and Assurance Committee (the Committee) is established by the Integrated Care Board (ICB) as a committee of the Board of the ICB (the Board) in accordance with its Constitution.
- 1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.
- 1.3 The Committee is a non-executive chaired committee of the Board, and its members are bound by the Standing Orders and other policies of the ICB.

2.0 Authority

- 2.1 The Primary Care Commissioning and Assurance Committee is accountable to the ICB and shall report to the Board on how it discharges its delegated primary care commissioning functions for primary medical services from July 2022 and primary community pharmacy, optometry and dental services from April 2023.
- 2.2 The ICB holds only those powers as delegated in these Terms of Reference as determined by the NHS England Commissioning Board.
- 2.3 The Committee is authorised by the Board to:
 - a) Investigate any activity within its terms of reference.
 - b) Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference.
 - c) Commission any reports it deems necessary to help fulfil its obligations.
 - d) Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so, the Committee must follow any procedures put in place by the ICB for obtaining legal and professional advice.
 - e) Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish groups in accordance with the ICB's Constitution, Standing Orders, Scheme of Reservation and Delegation but may not delegate any decisions to such groups.
- 2.4 For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation.

3.0 Purpose

- 3.1 The Committee exists to scrutinise and provide assurance to the ICB Board that there is an effective system of primary care services including medical, community pharmacy, optometry and dental services commissioning that supports it to effectively deliver its statutory and strategic objectives and provide sustainable, high quality primary care.
- 3.1.1 The Committee acknowledges in exercising the ICB's functions (including those delegated to it), it must comply with the statutory duties as set out in the NHS Act 2006 (as amended by the Health and Care Act 2022), including:
- a) Management of conflicts of interest (section 14O).
 - b) Duty to promote the NHS Constitution (section 14P).
 - c) Duty to exercise its functions effectively, efficiently and economically. (Section 14Q).
 - d) Duty as to improvement in quality of services (section 14R).
 - e) Duty in relation to quality of primary medical services (section 14S).
 - f) Duties as to reducing inequalities (section 14T).
 - g) Duty to promote the involvement of each patient (section 14U).
 - h) Duty as to patient choice (section 14V).
 - i) Duty as to promoting integration (section 14Z1).
 - j) Public involvement and consultation (section 14Z2).
 - k) Delivery of the ICB & Health & Care Partnership strategic objectives for primary care commissioning.
- 3.1.2 The Committee acknowledges that it is subject to any directions made by NHS England or the Secretary of State to the ICB.

3.2 Role of the Committee

- 3.2.1 The Committee has been established in accordance with the above statutory provisions to enable the members to, for example, make collective decisions on the review, planning and procurement of primary medical services, dental services. The Committee will receive assurance reports on community pharmacy market entry requests through the regionally established ICBs Pharmaceutical Services Regulatory Committee (PSRC) which BLMK under delegated authority from NHS England and optometry reports to provide the Committee with assurance from the hosted ICB that optometry services are being commissioned in line with statutory functions.
- 3.2.2 The role of the Committee shall be to carry out the functions relating to the commissioning of primary care services including primary medical, community pharmacy, optometry and dental services under section 83 of the NHS Act 2006 (as amended by the Health and Care Act 2006).
- 3.2.3 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS

England and Bedfordshire, Luton and Milton Keynes ICB which will sit alongside the Scheme of Reservation and Delegation and these terms of reference.

- 3.2.4 The functions of the Committee are undertaken in the context of a desire to promote increased quality, efficiency, productivity and value for money and to remove administrative barriers.
- 3.2.5 NHS Bedfordshire, Luton and Milton Keynes to receive assurance from the regional Pharmaceutical Services Regulatory Committee (PSRC) in relation to community pharmacy services including market entry requests.

4.0 Membership and attendance

- 4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.
- 4.2 The Board will appoint nine members of the Committee including two who are Non-Executive Members of the ICB Board. Other attendees of the Committee need not be members of the Board, but they may be.
- 4.3 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.
- 4.4 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.

Chair and Deputy Chair

- 4.5 The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.
- 4.6 If the Chair has a conflict of interest, then the Deputy Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

4.7 Members with Voting rights:

- a) Non-Executive Member (Chair)
- b) Non-Executive Member
- c) ICB Chief of Primary Care
- d) ICB Chief Finance Officer
- e) ICB Chief Nurse
- f) ICB Chief Medical Director
- g) Three Clinical Representatives who have primary care leadership experience delivering either primary medical, primary dental and primary

ophthalmic services or services that may be provided as pharmaceutical services, following appointment of the ICB Partner Members or clinical lead roles. One of these members will be the Deputy Chair of the Committee.

4.8 Other attendees – non voting.

4.8.1 The following non-voting attendees will be invited to attend the meetings of the Primary Care Commissioning and Assurance Committee, as subject area specialists and as pertinent to Agenda items:

- a) Deputy Chief of Primary Care
- b) Associate Director of Primary Care Contracting and Development
- c) Associate Director of Primary Care and Prevention
- d) Associate Director of Pharmacy and Medicines Optimisation
- e) Non-executive member
- f) One representative from each Healthwatch in BLMK (4)
- g) One representative from each Local Medical Committee (2)
- h) One representative from the Local Pharmaceutical Committee
- i) One representative from each Local Optometry Committee (2)
- j) One representative from each Local Dental Committee (2)
- k) One representative from each Health and Wellbeing Board in BLMK (4)]
- l) One Public Health representative for each local authority area (2).

5.0 Meeting Quoracy and Decisions

5.1 The Primary Care Commissioning and Assurance Committee shall meet in private quarterly. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

a)

Quorum

5.2 For a meeting to be quorate the following four members need to be present; one non-executive member - Chair for the meeting, ICB Chief of Primary Care or ICB Chief Medical Director, ICB Chief Finance Officer plus one other ICB Executive Board Member.

5.3 Where members are required for quoracy but unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate and vote on their behalf. No other deputies are permissible.

Decision making and voting.

- 5.4 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
- 5.5 Only voting members of the Committee, or deputies for members required for quoracy, may vote. Each voting member is allowed one vote and a majority will be conclusive on any matter.
- 5.6 Where there is no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

6.0 Responsibilities of the Committee

- 6.1 The responsibilities of the Primary Care Commissioning and Assurance Committee are authorised by the Board of the ICB. The Committee is responsible for providing the ICB Board with assurance in relation to its decisions for the commissioning, procurement and management of primary care contracts including primary medical (GP), community pharmacy, optometry and dental services including, but not limited to the following activities:
- a) Review and approve recommendations made by the Primary Care Delivery Group to ensure the ICB is meeting its statutory responsibilities for commissioning and overseeing delegated primary care services and functions to include:
 - i. General Medical Services (GMS) and Alternative Provider of Medical Services (APMS) contracts (including the design of APMS contracts, performance of contracts, appropriate contractual action such as issuing breach/remedial notices and removing a contract) has been applied.
 - ii. Assurance on contractual compliance and decision making in relation to the management of poorly performing medical (GP), community pharmacy, optometry and dental practices and including, without limitation, decisions and liaison with the Care Quality Commission where the Care Quality Commission has reported non-compliance with standards (but excluding any decisions in relation to the performers list).
 - iii. Receive optometry reports to provide the Committee with assurance from the hosted ICB that optometry services are being commissioned in line with statutory functions.
 - iv. Receive Pharmaceutical Services Regulatory Committee (PSRC) reports to provide the committee with assurance the PSRC is implementing the requirements of the community pharmacy regulatory framework.
 - v. Approve the development (subject to financial authorisation) of newly designed services for all contractor groups and

implementation of financial services or local incentive schemes and other ancillary activities as appropriate.

- vi. Decision making on whether to establish new GP and dental practices (including branch surgeries) and closures of GP and dental practices.
 - vii. Approve the primary care procurement plans and approve the recommendations by the Primary Care Delivery Group to award new contracts on completion of procurements.
 - viii. Ensure compliance with Premises Costs Directions (2015) for primary medical services.
 - ix. Oversee the planning and preparedness for the delegation of NHS England Public Health (section 7a) services of vaccinations and immunisations with recommendations to the ICB Board for the services to be delegated to the ICB in 2025.
-
- b) Utilise local clinical knowledge to influence the development of and investment in primary care to improve access to all primary care commissioned services and taking a population health management approach.
 - c) Develop and commission end to end care and increased autonomy to shape future primary care services including medical services (GP), community pharmacy, optometry and dental services.
 - d) Take an active role in driving forward the NHS Long Term Plan.
 - e) Provide assurance on the delegated budget for commissioning of primary medical services including community pharmacy, optometry and dental services in Bedfordshire, Luton and Milton Keynes.
 - f) Plan, primary medical care, community pharmacy, optometry and dental services in the BLMK area in response to population health assessments.
 - g) Undertake reviews of primary care services in the BLMK area, including primary medical services, community pharmacy, optometry and dental services.
 - h) Co-ordinate a common approach to the commissioning of primary care services.
 - i) Ensure collaborative working on monitoring and addressing issues of quality in primary care based on the principle of continuous improvement.
 - j) Recommend the key primary care priorities that are included within the ICB strategy/annual plan, including priorities to address variation/inequalities in care.
 - k) Oversee and monitor delivery of primary care related ICB key statutory requirements.

- l) Review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to primary care, and high-risk operational risks which could impact on care. Ensure the Board is kept informed of significant risks and mitigation plans, in a timely manner.
- m) Oversee and scrutinise the ICB's response to all relevant (as applicable to primary care) Directives, Regulations, national standards, policies, reports, reviews and best practice as issued by the Department of Health and Social Care, NHS England and other regulatory bodies / external agencies (e.g. Care Quality Commission, National Institute of Clinical Excellence), to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.
- n) Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the Board that these are disseminated and implemented across all sites.
- o) Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place.
- p) 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.
- q) Oversee the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety.
- r) Have oversight of and recommend approval of the terms of reference and approve work programmes for the groups reporting into the Primary Care Commissioning and Assurance Committee.
- s) Provide assurance on the transformation and integration programme for primary care which includes the ambitions in the NHSE 'Fuller Stocktake Report' (May 2022), the NHSE 'Delivery Plan for Improving Access to Primary Care' (May 2023) and the ICB's 'Delivery Plan for 'Prevention in Primary Care Settings' (January 2024).
- t) The Committee will provide regular assurance updates to the Board in relation to activities and items within its remit.
- u) Provide assurance on delivery of the Primary Care Strategy through the BLMK Fuller Neighbourhood Programme.

6.2 Delegation of functions and decisions to the Primary Care Delivery Group

The following operational functions and decisions in relation to General Practice, community pharmacy, optometry and dental services are delegated to the Executive led Primary Care Delivery Group, from the Primary Care Commissioning and Assurance Committee and these are:

- i. Oversee commissioning and operational delivery of primary care contracts including the design of Alternative Provider of Medical Services and Personal Dental Service contracts.
- ii. Monitoring of contracts taking contractual action such as issuing remedial and breach of contract notices and or termination of contracts in line with the terms of the contracts and national policy guidance manuals.
- iii. Oversee the programme of Alternative Provider of Medical Services and Personal Dental Service and other procurements and make recommendations to the PCCAC for contract award.
- iv. Oversee the development (subject to financial authorisation) of newly designed enhanced services “Local Enhanced Services” and implementation of “Directed Enhanced Services” and “Local Incentive Schemes
- v. Approving practice mergers.
- vi. Approving contractors change of boundary requests and relocation requests.
- vii. Approve dental contractors change of hours of service delivery.
- viii. Approving requests to convert General Dental contracts to Personal Dental contracts.
- ix. Approving primary care medical and dental incorporation applications
- x. Oversee and approve the rebasing of dental contracts.
- xi. Making decisions on discretionary payments including Section 96 emergency financial support, within the Chief of Primary Care Executives SFO authorisation limits
- xii. Making decisions relating to Primary Care Estates issues.
- xiii. Making decisions relating to Primary Care Digital issues.
- xiv. Making decisions relating to Primary Care Workforce.

6.2.1 The Primary Care Delivery Group will report decisions it has made to the Primary Care Commissioning and Assurance Committee at each meeting to provide oversight and assurance.

7.0 Behaviours and Conduct

ICB Values

7.1 Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB’s Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and Diversity

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

Declarations of Interest

- 7.3 All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

8.0 Accountability and reporting

- 8.1 The Primary Care Commissioning and Assurance Committee is directly accountable to the Board. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.
- 8.2 The Committee will advise the Audit and Risk Assurance Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.
- 8.3 The Committee will receive scheduled assurance report from its delegated group the Executive led Primary Care Delivery Group which will include quarterly assurance reports from the Primary Care Workforce & Education Network Training Hub Steering Group, the Estates Working Group, the region wide Secondary Care Dental Screening Group and the region wide Pharmaceutical Services Regulatory Committee. Any delegated groups would need to be agreed by the ICB Board.

9.0 Secretariat and Administration

- 9.1 The Committee shall be supported with a secretariat function which will include ensuring that:
- The agenda and papers are prepared and distributed at least five working days before each meeting in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
 - Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not attend at least 75% of meetings.
 - Records of members' appointments and renewal dates are reviewed and the Board is prompted to renew membership and identify new members where necessary.
 - Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
 - The Chair is supported to prepare and deliver reports to the Board.
 - The Committee is updated on pertinent issues/ areas of interest/ policy developments.
 - Action points are taken forward between meetings and progress against those actions is monitored.

10.0 Review

- 10.1 The Committee will review its effectiveness at least annually.
- 10.2 These Terms of Reference will be reviewed at least every two years and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.
- 10.3 The Committee will use a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Appendix G - Primary Care Delivery Group Terms of Reference

The Primary Care Delivery Group is an executive led sub-group of the Primary Care Commissioning and Assurance Committee (PCCAC). The PCCAC was established by Bedfordshire Luton and Milton Keynes Integrated Commissioning Board (BLMK ICB) in July 2022 and reports to the Board of the ICB in accordance with its constitution.

1.0 Authority

- 1.1 The Primary Care Commissioning and Assurance Committee has delegated authority to the Chief of Primary Care to oversee the executive led Primary Care Delivery Group as set out in the ICB committee structure annex 1.

2.0 Purpose

- 2.1 The Primary Care Delivery Group is to enable the Chief Primary Care Officer to focus and oversee the management and delivery of the entire primary medical (GP), community pharmacy, optometry and dental services programmes of work in the context of promoting increased quality, efficiency, productivity, value for money and reducing administration burden whilst providing assurance reports to the PCCAC at each meeting on the following functions.
- a) Business as usual operational issues.
 - b) Oversee the implementation of primary care transformation adhering to the principle of subsidiarity.
 - c) Implementation and delivery on the transformation and integration programme for primary care which includes the ambitions in the NHSE 'Fuller Stocktake Report' (May 2022), the NHSE 'Delivery Plan for Improving Access to Primary Care' (May 2023) and the ICBs 'Delivery Plan for Prevention in Primary Care Settings' (January 2024).
 - d) Promotion of working collaboratively with the finance, quality and safeguarding and estates directorates and wider system health and care partners to support the delivery of primary medical services.
 - e) To give financial approval within the Chief Primary Care Officers financial authorisation level set out in the Statement of Financial Orders (SFOs).
 - f) Financial approval outside of the Chief Primary Care Officers financial authorisation, will be requested from the PCCAC.

3.0 Membership and attendance

- 3.1 The PCDG will meet on a monthly basis as convened by the Group Chair.
- 3.2 The core membership of the PCDG will include the following representation or their designate:

Members with voting rights:

- a) ICB Chief Primary Care Officer (Chair)
- b) ICB Deputy Chief Primary Care Officer (Vice Chair)
- c) ICB Associate Director of Primary Care Contracting & Development

- d) ICB Associate Director of Primary Care and Prevention.
- e) ICB Associate Director of Finance
- f) ICB Associate Director of Quality Improvement & Inequalities
- g) ICB Associate Director System and ICB Estates.

3.3 Other attendees - non-voting

- a) ICB Associate Director of Pharmacy and Medicines Optimisation
- b) ICB Head of Primary Care Workforce Programme
- c) ICB Head of Community and Primary Care Contracting
- d) ICB Senior Contract Managers GP and Dental services
- e) ICB Heads of Integrated Care
- f) ICB Strategic Clinical Leads
- g) ICB Community Pharmacy Integration Lead
- h) ICB Associate Director People Transformation
- i) One representative from each Local Medical Committee (2)
- j) One representative from each Local Dental Committees (2)
- k) One representative from the Local Pharmaceutical Committee
- l) One representative from each Local Optometry Committees (2)
- m) One representative from each Health and Wellbeing Board in BLMK (4)
- n) One Public Health representative for each Local Authority area (2)

3.4 Other members will be co-opted as and when appropriate including, but not limited to:

- a) Senior Finance Manager
- b) Senior Public Health
- c) Others to be agreed.

4.0 Meeting Quoracy and Decisions

Quorum

- 4.1 Quoracy will be a minimum four representatives - Chief Primary Care Officer (Chair) or Deputy Chief Primary Care Officer (Vice Chair), Associate Director of Primary Care Contracting and Development, Associate Director of Finance and Associate Director of Quality Improvement & Inequalities or Associate Director System and ICB Estates.
- 4.2 Where members are required for quoracy but unable to attend, they should ensure that a named and briefed deputy is in attendance who can participate and vote on their behalf.

Decision making and voting

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

- 4.4 Only voting members of the group may vote. Each voting member is allowed one vote and a majority will be conclusive on any matter.
- 4.5 Voting members and responsible officers unable to attend the PCDG may appoint a deputy to attend and vote on their behalf. No other deputies are permissible.
- 4.6 Where there is a split vote, with no clear majority, the Chair of the Group will hold the casting vote. The result of the vote will be recorded in the minutes.
- 4.7 There may be times that decisions will need to be taken outside the meeting and subject to agreement with key representatives including the Chair of the Primary Care Commissioning & Assurance Committee or deputy. This will include contracting decisions e.g., list closure applications where a decision is required within 21 days of receipt of practice applications. Such decisions will be reported to the next PCCAC meeting.

5.0 Responsibilities of the Group

- 5.1 The responsibilities of the Primary Care Delivery Group will be delegated by the Primary Care Commissioning and Assurance Committee; it is expected these will be the focus areas:

5.1.1 Operational

- i. Oversee commissioning and operational delivery of all primary care contracts including the design of Alternative Provider of Medical Services and Personal Dental Service contracts and Specialist Community Dental Services.
- ii. Monitoring of contracts taking contractual action such as issuing remedial and breach of contract notices and or termination of contracts in line with the terms of the contracts and national policy guidance manuals.
- iii. Oversee the programme of Alternative Provider of Medical Services and Personal Dental Service and other procurements and make recommendations to the PCCAC for contract award.
- iv. Oversee the development (subject to financial authorisation) of newly designed enhanced services “Local Enhanced Services” and implementation of “Directed Enhanced Services” and “Local Incentive Schemes.”
- v. Approving practice mergers.
- vi. Approving changes to practice boundaries, relocation requests.
- vii. Approving list closure applications.
- viii. Approving requests to convert General Dental Services to Personal Dental Services contracts.
- ix. Agree change of dental contractor hours.
- x. Oversee and approve the rebasing of dental contracts.
- xi. Approving primary care medical and dental services incorporation applications.

- xii. Making decisions on discretionary payments including Section 96 emergency financial support, within the Chief Primary Care Officer Executives SFO authorisation limits.
- xiii. Making decisions relating to Primary Care Estates.
- xiv. Making decisions relating to Primary Care digital issues.
- xv. Making decisions relating to Primary Care workforce.
- xvi. Undertake reviews of primary medical and dental services in the BLMK area and co-ordinate a common approach to the commissioning of primary care services.
- xvii. Utilise local clinical and management knowledge to influence the development of and investment in general practice to improve patient access to services and taking a population health management approach.
- xviii. Develop and commission end to end care and shape future primary care services.
- xix. Provide the PCCAC with an annual work plan outlining key committee dates to receive specific reports in addition to the quarterly assurance reports.
- xx. Oversee the delivery of the ICB Vaccination strategy.

5.1.2 Strategic

- i. Take an active role in driving forward the NHS Long Term Plan.
- ii. Plan primary care services in the BLMK area in response to population health assessment.
- iii. Oversee the planning and preparedness for the delegation of NHS England Public Health (section 7a) services, vaccinations and immunisations to the ICB in 2025.
- iv. Promote collaborative working on monitoring and addressing issues of quality in primary care based on the principle of continuous improvement.
- v. Make recommendations to the PCCAC on whether to establish new GP practices in an area subject to the Committee's agreement.
- vi. Agree and put forward the key primary care priorities that are included within the ICB strategy/annual plan, including priorities to address variation/inequalities.
- vii. Promote collaborative working and interconnectivity with the Quality and Safeguarding Group, Estates Working Group, Workforce & Education Network Training Hub Steering Group and Digital Group.
- viii. Review and monitor primary care risks and mitigations to provide assurance to the PCCAC.
- ix. Monitor, review risks on the Board Assurance Framework (BAF) and Corporate Risk Register which relate to primary care to include identifying new risks.
- x. Ensure the Primary Care Commissioning and Assurance Committee is kept informed of significant risks and mitigation plans, in a timely manner.

5.1.3 Assurance reporting to the PCCAC

- i. Provide assurance to the Committee to manage the overall budget for commissioning of primary medical, community pharmacy, optometry and dental services.
- ii. Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the PCCAC that these are disseminated and implemented across all sites and that they are appropriately reviewed, and actions are being undertaken, embedded, and sustained.
- iii. Provide assurance that the mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by primary care providers and place.
- iv. Ensure risks both financial and operational are highlighted to the Committee with the appropriate mitigation plans.
- v. Provide assurance on the transformation and integration programme for primary care which includes the ambitions in the NHSE 'Fuller Stocktake Report' (May 2022), the NHSE 'Delivery Plan for Improving Access to Primary Care' (May 2023) and the ICBs 'Delivery Plan for Prevention in Primary Care Settings` (January 2024).

6.0 Behaviours and Conduct

ICB Values

- 6.1 Members of the Primary Care Delivery Group will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Primary Care Delivery Group shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and Diversity

- 6.2 Members of the Primary Care Delivery Group must consider the equality and diversity implications of decisions they make.

Declarations of Interest

- 6.3 All members of the Primary Care Delivery Group and those in attendance declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Chair.

7.0 Accountability and reporting

- 7.1 The Primary Care Delivery Group is directly accountable to the Primary Care Commissioning and Assurance Committee (Appendix 1). The minutes of meetings shall be formally recorded.
- 7.2 The Chair of the Group shall report to the Primary Care Commissioning and Assurance Committee and provide an assurance report to the committee on a

quarterly basis and escalate concerns to the Chair of the PCCAC where necessary.

7.3 The Group will work collaboratively to ensure interconnectivity with other ICB Executive Led Groups including but not limited to finance and estates, quality and safeguarding and ICS system stakeholders.

7.4 The Primary Care Training Hub Steering Group and Estates Working Group will report into the Primary Care Delivery Group.

8.0 Secretariat and Administration

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

- i. The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Associate Director.
- ii. attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- iii. Records of members and conflicts of interest will be declared and recorded at each meeting.
- iv. Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- v. The Chair is supported to prepare and deliver reports to the Primary Care Commissioning and Assurance Committee.
- vi. The Group is updated on pertinent issues/ areas of interest/ policy developments.
- vii. Action points are taken forward between meetings and progress against those actions is monitored.

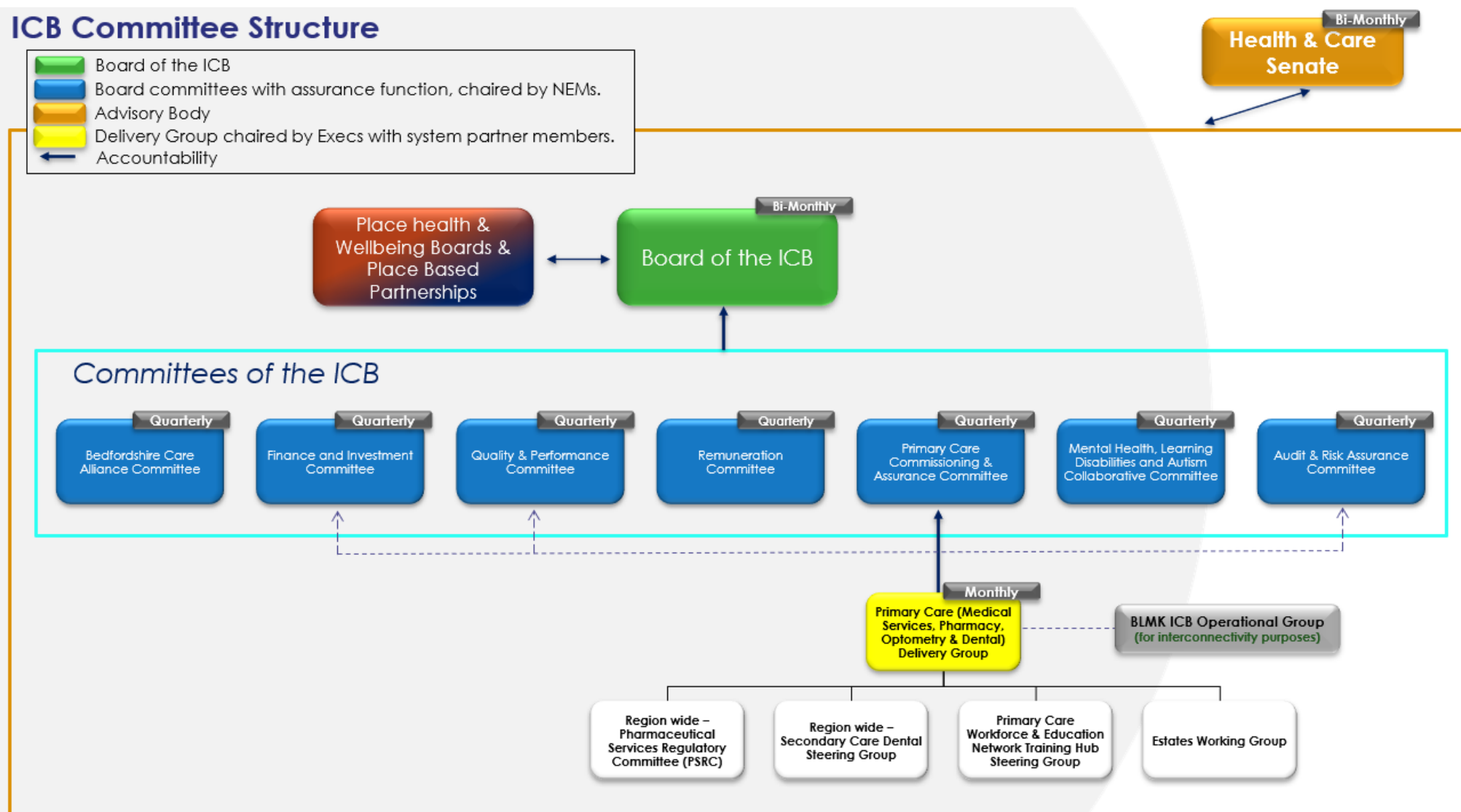
9.0 Review

9.1 The Terms of Reference will be reviewed at least annually and more frequently if required. The Terms of Reference and any proposed amendments will be submitted to the Primary Care Commissioning and Assurance Committee for approval.

Annex 1 Bedfordshire, Luton and Milton Keynes - ICB Committee Structure

ICB Committee Structure

- Board of the ICB
- Board committees with assurance function, chaired by NEMs.
- Advisory Body
- Delivery Group chaired by Execs with system partner members.
- Accountability



Appendix H BLMK ICB Mental Health, Learning Disabilities and Autism Collaborative Committee Terms of Reference

1.0 Introduction

- 1.1 The Bedfordshire, Luton and Milton Keynes Integrated Care Board ('ICB') and the following NHS providers of mental health, learning disability and autism ('MHLDA') services, who are all partners of the Bedfordshire, Luton and Milton Keynes ('ICS'), have come together to form the Bedfordshire, Luton, Milton Keynes MHLDA Collaborative Committee. The NHS providers of MHLDA services are:
- (a) East London NHS Foundation Trust ('ELFT'); and
 - (b) Central North West London NHS Foundation Trust ('CNWL').
- 1.2 For the purpose of these terms of reference, the providers and the ICB shall be known as the 'NHS Partner Organisations.'
- 1.3 The Committee has been established with a view to enabling the ICB and the NHS Partner Organisations to work collaboratively, with a shared purpose, and at scale across multiple places in Bedfordshire, Luton and Milton Keynes ('BLMK'), to improve outcomes, quality, value and equity for residents of BLMK with, or at risk of, MHLDA.

2.0 Constitution

- 2.1 The Mental Health, Learning Disabilities and Autism (MHLDA) Collaborative Committee (the Committee) is established by the Integrated Care Board (ICB) as a Committee of the Board of the ICB in accordance with its Constitution.
- 2.2 These Terms of Reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board of the ICB.
- 2.3 The Committee is a Committee of the Board and its members, including those who are not members of the Board of the ICB, are bound by the Standing Orders⁶ and other policies of the ICB.
- 2.4 The members of the Committee are the leaders of the MHLDA collaborative, responsible for discharging the duties of the Committee.

3.0 Authority

- 3.1 The Committee is authorised by the Board of the ICB to:
- investigate any activity within its terms of reference.

⁶ <https://bedfordshirelutonandmiltonkeynes.icb.nhs.uk/~documents/governance/nhs-blmk-icb-governance-handbook>

- seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) or from employees of partner organisations, the latter having committed to co-operate with any request made by the Committee, as outlined in these terms of reference;
 - commission any reports it deems necessary to help fulfil its obligations;
 - obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice; and
 - create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation but may not delegate any decisions to such groups.
- 3.2 For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation.

4.0 Purpose

4.1 The Committee has been established to:

- provide the ICB and NHS Partner Organisations with the ability to collaboratively direct and oversee the delivery of high quality patient care relating to in-scope MHLDA services in BLMK in order to:
 - (a) improve outcomes in population health and healthcare;
 - (b) tackle inequalities in outcomes, experience and access;
 - (c) enhance productivity and value for money; and
 - (d) help the NHS support broader social and economic development; and
- contribute to the overall delivery of the ICB objectives, priorities and the Joint Forward Plan by providing oversight and assurance to the Board for the development and commissioning of mental health, learning disabilities and autism (MHLDA) services.

5.0 Membership and attendance

Membership

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

5.2 The Board will appoint the following members of the Committee including two who are independent non-executive members of the Board of the ICB. Other members of the Committee need not be members of the Board of the ICB as long as they can carry out appropriate duties on behalf of their parent organisations. The Committee Members will be:

- Non-Executive Member (ICB);
- Non-Executive Member (ICB);
- Non-Executive Director (ELFT);
- Non-Executive Director (CNWL);
- Chief Operating Officer (ICB)
- Chief Nurse (ICB);
- Chief Financial Officer (ICB);
- Board executive director, or nominated deputy (CNWL);
- Clinical Executive (CNWL);
- Chief Executive Officer (CNWL);
- Board executive director, or nominated deputy (ELFT);
- Clinical Executive (ELFT);
- Chief Executive Officer (ELFT); and
- Service user / Carer representatives (x 4).

5.3 When determining the membership of the Committee, active consideration will be made to equality and diversity, especially in relation to appropriate skills and background to ensure a broad range of views are represented on the Committee.

Chair and Deputy Chair

5.4 In accordance with the Constitution, the Committee will be chaired by an independent non-executive member of the ICB Board.

5.5 Committee members may appoint a deputy chair from amongst its non-executive members.

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

Attendees

5.6 The Committee may also have regular attendees who will receive advanced copies of the notice, agenda, and papers for meetings as appropriate to the agenda items. They may be invited to attend any or all the meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote. Regular attendees will include the following:

- Primary Medical Services representative* (1);
- Representative of children's social services* (1);
- Representative of directors of adult social services* (1);

- Representative of directors of public health* (1); and
- Representative from the voluntary, community and social enterprise sector (1).

Roles marked * will each represent a different place in BLMK.

- 5.7 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters or to manage agenda item-specific conflicts of interest.
- 5.8 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any matter.

Attendance

- 5.9 Where a member (or nominated deputy for providers) of the Committee is unable to attend a meeting, a suitable alternative may be agreed with the Chair but will not be counted towards quoracy and may not vote.

6.0 Meeting Quoracy and Decisions

- 6.1 The Committee will meet at least four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.
- 6.2 Further meetings of the Committee may be convened at the request of any member of the Committee through the Chair.
- 6.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

- 6.4 For a meeting to be quorate the following must be in attendance:
- a minimum of 50% of the members including;
 - at least one ICB non-executive member or provider non-executive director; and
 - at least one representative from the ICB;
 - at least one member from ELFT;
 - at least one member from CNWL; and
 - at least one service user/care representative.
- 6.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a conflict of interest, then that individual shall no longer count towards the quorum.
- 6.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

- 6.7 If a quorate meeting cannot be held (due to conflicts of interest) then the Committee should recommend a course of action to the Board for it to make a decision, or to delegate that decision to an existing or ad-hoc body set up for the purpose.

Decision making and voting

- 6.8 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach decisions by consensus. When this is not possible the Chair may call a vote.
- 6.9 Only members of the Committee may vote. Attendees are not entitled to vote but their views will be taken into account. Each member is allowed one vote and a majority will be conclusive on any matter. Where there no clear majority, the Chair of the Committee will hold the casting vote.
- 6.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication. Where any such action has been taken between meetings, this will be reported to the next meeting.

7.0 Responsibilities of the Group

- 7.1 The Committee's duties include the following:
- 7.1.1 to support the development of further collaboration between the ICB and NHS Partner Organisations (including working together towards the Committee receiving a formal delegation for the functions associated with the Mental Health Investment Standard and other investment into mental health, and exploring opportunities for formal joint working);
 - 7.1.2 to ensure and encourage the engagement of all the partner organisations of the ICS, with a view to shaping the future of MHLDA services across BLMK;
 - 7.1.3 to coordinate work to reduce inequalities in health outcomes, access and experience where it is the case that action across the NHS Partner Organisations and/or the ICS is required, striving to embed joint accountability;
 - 7.1.4 to coordinate improved resilience of services (e.g. by mutual aid) where it is the case that action across the NHS Partner Organisations and/or the ICS is required;
 - 7.1.5 to co-ordinate work across partners to ensure that specialisation and consolidation can occur where this will provide better outcomes and value;

- 7.1.6 to ensure that people participation is at the heart of all the activities of the Committee, and of the collaborative's wider work to ensure the needs and experiences of communities are considered over whole pathways of care;
 - 7.1.7 to lead the development of the ICS strategy for MHLDA, and put in place arrangements to ensure its delivery with ICS partners including the four place-based partnerships and the Bedfordshire Care Alliance;
 - 7.1.8 to contribute to the overall delivery of the ICB priorities and the Joint Forward Plan by providing oversight and assurance to the Board for the development and commissioning of mental health, learning disabilities and autism (MHLDA) services, including service user and carer led priorities, and the NHS national plans and priorities; and agree mitigations where there are significant delivery risks;
 - 7.1.9 to lead annual planning to meet the needs of people for MHLDA services in BLMK across the ICS;
 - 7.1.10 to advise on and recommend future commissioning decisions for MHLDA services to the Board; and
 - 7.1.11 to enable the exercise of the Delegated Functions in a simple and efficient way. Annex 1 lists the Delegated Functions, which have been delegated to the Committee by the ICB. Matters delegated to the Committee are also set out in an operational scheme of delegation, which has been developed by the ICB. The Committee, through its members set out at section 5, above is authorised by the Board to take decisions in relation to those matters on behalf of the ICB.
- 7.2 The Committee does not hold delegated functions from ELFT or CNWL. However, members of the Committee from those organisations may have appropriate delegated responsibility from their partner organisation to make decisions on behalf of their organisation in connection with MHLDA or, at least, will have sufficient responsibility to discuss matters on behalf of their organisation and be ready to move programmes of work forwards by holding discussions in their own organisation and escalating matters of importance.
- 7.3 As the list of Delegated Functions develops, they shall be exercised with particular regard to the Committee's priorities and objectives, as described in the MHLDA Plan, which the Committee shall develop and which will be approved by the Integrated Care Board, and by the other NHS Partner Organisations in accordance with their own governance requirements.
- 7.4 In addition, the Committee will support the ICB, and where relevant the other NHS Partner Organisations, to achieve the aims and the ambitions of:
- (a) the Joint Forward Plan;
 - (b) the Integrated Care Strategy prepared by the BLMK Integrated Care Partnership;

(c) the joint local health and wellbeing strategies and associated needs assessments prepared by the five health and wellbeing boards; and
(d) the plans prepared by the four place-based partnerships, within the ICS's area.

- 7.5 The Committee will prioritise its work against the strategic priorities of the ICS and the ICS operating principles set out [here](#).
- 7.6 In supporting the NHS Partner Organisations to discharge their statutory functions and deliver the strategic priorities of the ICS, the Committee will, in turn, be supporting the ICS with the achievement of the 'four core purposes' of Integrated Care Systems, namely to:
- (a) improve outcomes in population health and healthcare;
 - (b) tackle inequalities in outcomes, experience and access;
 - (c) enhance productivity and value for money; and
 - (d) help the NHS support broader social and economic development.
- 7.7 The Committee is also a key component of the ICS, enabling it to meet the 'triple aim' of better health for everyone, better care for all and efficient use of NHS resources.
- 7.8 The NHS Partner Organisations acknowledge that 2024/2025 is a transitional year and, accordingly, the focus of the Committee will be on determining the vision and arrangements for future collaboration. Consequently, it is expected that the arrangements described in these terms of reference will evolve, including to bring further functions within scope overtime.

8.0 Behaviours and Conduct

Values

- 8.1 Members will be expected to conduct business in line with the values of the ICB and providers and in line with the MHLDA Collaborative Partnership Agreement.
- 8.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution⁷, Standing Orders⁸, and Conflicts of Interest and Standards of Business Conduct Policy⁹.
- 8.3 Committee members will ensure engagement takes place with other non-NHS sectors, such as police, ambulance and fire services.

⁷ <https://bedfordshirelutonandmiltonkeynes.icb.nhs.uk/~documents/policies/nhs-blmk-icb-constitution-01-07-22-nhse-approved>

⁸ <https://bedfordshirelutonandmiltonkeynes.icb.nhs.uk/~documents/governance/nhs-blmk-icb-governance-handbook>

⁹ <https://bedfordshirelutonandmiltonkeynes.icb.nhs.uk/~documents/policies/operational-policies/conflict-of-interest-management-standards-of-business-conduct-policy-v1-0>

Conflicts of interest

- 8.4 In discharging duties transparently, any potential conflicts of interest must be considered, recorded and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest.
- 8.5 All potential conflicts of interest must be declared and recorded at the start of each meeting. The Chair will determine any action to be taken should a conflict or potential conflict become apparent, but with the intention of inclusion and transparency wherever possible.

Equality and diversity

- 8.6 Members must consider the equality and diversity implications of decisions they make.

9.0 Accountability and reporting

- 9.1 The Committee is accountable to the Board of the ICB and shall report to the Board on how it discharges its responsibilities.
- 9.2 The Chair will provide assurance reports to the Board after each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.
- 9.3 The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference, details on progress and a summary of key achievements in delivering its responsibilities.
- 9.4 Members and attendees from organisations other than the ICB are responsible for reporting to their boards or governing bodies as necessary.

10.0 Secretariat and Administration

- 10.1 The Committee shall be supported with a secretarial function which will include ensuring that:
- the agenda and papers are prepared and distributed at least five working days before each meeting in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
 - attendance of those invited to each meeting is monitored and highlighted to the Chair those that do not meet the minimum requirements;
 - records of members' appointments and renewal dates and that the Board is prompted to renew membership and identify new members where necessary;
 - good quality minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;
 - the Chair is supported to prepare and deliver reports to the Board;

- the Committee is updated on pertinent issues, areas of interest or policy developments; and
- action points are taken forward between meetings and progress against those actions is proactively monitored.

11.0 Review

11.1 The Committee will review its effectiveness at least annually.

These Terms of Reference will be reviewed within the first year and any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

Appendix I– Health and Care Partnership (Joint Committee) Terms of Reference

1.0 Introduction

1.1 The Bedfordshire, Luton and Milton Keynes Health and Care Partnership is the name of the system’s Integrated Care Partnership (ICP) in accordance with the Health and Care Act 2022 and is established in accordance with NHS Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board (ICB) Constitution, and the Constitutions of the five local authorities in the system, as a Joint Committee of the Integrated Care Board and the local authorities of Bedford Borough Council, Central Bedfordshire Council, Buckinghamshire Council, Luton Borough Council and Milton Keynes Council.

2.0 Membership

2.1 The membership of the ICP shall include:

2.2 Core Members

Organisation	Role
NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board	Chair Chief Executive Officer
Bedford Borough Council	Health and Wellbeing Board Chair One or two further people appointed by the Council (suggest one member is from children’s and one member is from adult services)
Buckinghamshire Council	One person as nominated by the Council
Central Bedfordshire Council	Health and Wellbeing Board Chair One or two further people appointed by the Council (suggest one member is from children’s and one member is from adult services)
Luton Borough Council	Health and Wellbeing Board Chair One or two further people appointed by the Council (suggest one member is from children’s and one member is from adult services)
Milton Keynes Council	Health and Wellbeing Board Chair One or two further people appointed by the Council (suggest one member is from children’s and one member is from adult services)
Director of Public Health (2)	Bedford Borough, Central Bedfordshire and Milton Keynes Councils Luton Borough Council
Bedfordshire Hospitals NHS Foundation Trust	Chair
Milton Keynes University Hospital NHS Foundation Trust	Chair
Cambridgeshire Community Services NHS Trust	Chair

Organisation	Role
East London NHS Foundation Trust	Chair
Central and North West London Foundation Trust	Chair
South Central Ambulance Service NHS Foundation Trust	Chair or nominated deputy
East of England Ambulance Service NHS Trust	Chair or nominated deputy
Primary Care Networks a Clinical Director from:	Bedford Luton Central Bedfordshire Milton Keynes
Healthwatch A local representative from:	Bedford Luton Central Bedfordshire Milton Keynes
NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board's Health and Care Senate	A representative
Voluntary, Community and Social Enterprise	BLMK nominated representative

2.3 Regular Participants

2.3.1 The Joint Committee may invite specified individuals to be Participants at its meetings to inform decision-making and the discharge of its functions as it sees fit. Participants will receive advanced copies of the notice, agenda and papers for meetings. They may be invited to attend any or all the meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote.

2.3.2 The following individuals will be regular participants:

Organisation	Role
NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board	Non-executives, executives, primary care partner members – as relevant to agenda items
Local Authorities in BLMK	As requested by local authorities and as relevant to agenda items
NHS Trusts in BLMK	CEOs and others as relevant to agenda items
Bedfordshire Fire and Rescue Service	Nomination from Fire and Rescue Service
Buckinghamshire Fire and Rescue Service	Nomination from Fire and Rescue Service
Thames Valley Police	Nomination from Police
Bedfordshire Police	Nomination from Police
Housing	Relevant to agenda items
Education	Relevant to agenda items
Criminal Justice	Relevant to agenda items
Voluntary, Community and Social Enterprise leads	Relevant to agenda items
Community Groups	Relevant to agenda items

Organisation	Role
Carers Representative	Relevant to agenda items

2.3.3 The Joint Committee may invite any individuals, groups or subject matter experts for specific items on the agenda for the meeting.

3.0 Joint Committee Chair

3.1 The Joint Committee Chair will be nominated by the Councils in BLMK and will be appointed by the ICP at its first meeting and serve for a two-year period.

3.2 The Councils in BLMK will nominate a deputy Chair who will be appointed by the Joint Committee at its first meeting and will Chair the Joint Committee meeting in the absence of the Joint Committee Chair. This appointment will also be for a two-year period.

4.0 Quorum

4.1 At least half of the members of the Joint Committee must be present for a quorum to be established including at least one member from the ICB and one member from two of the local authorities.

4.2 No formal business shall be transacted where a quorum is not reached.

5.0 Frequency of meetings and attendance

5.1 A minimum of two scheduled meetings shall be held per year and if the meetings are face to face will be held in each of the four Places in rotation and will be scheduled at different times and days of the week.

5.2 Members of the Joint Committee should make every effort to attend all meetings of the Committee and it is expected that core members attend at least 75% of Joint Committee meetings. The Secretary to the Joint Committee will monitor attendance and will report on this annually. Attendance figures will be published in the Annual Report.

6.0 Meetings to be held in public

6.1 The meetings of the Joint Committee will be held in public in accordance with the Public Bodies Admission to Meetings Act 1960. The Joint Committee may resolve to hold part of its meeting in private if it would be prejudicial to the public interest to meet in public.

6.2 The Joint Committee may hold regular workshops which will not be formal meetings of the Joint Committee, will not be taking decisions and will not be held in public. These workshops will be open to a wider group of participants than Joint Committee members and participants and will be forums for discussion to develop proposals for later consideration by the Joint Committee at a formal meeting.

7.0 Agenda setting

7.1 The agenda for Joint Committee meetings and workshops will be set by the Joint Committee's agenda setting group comprising of:

- Joint Committee Chair.
- ICB Chair.
- Health and Wellbeing Board Chairs (or nominated deputies) of Bedford Borough Council, Buckinghamshire Council, Central Bedfordshire Council, Luton Council and Milton Keynes Council.

7.2 A forward plan of items for consideration will be included in the agenda papers for each Joint Committee meeting.

8.0 Duties

8.1 It is the duty of the Joint Committee to develop, agree and monitor the implementation of the Integrated Population Health Strategy for Bedfordshire, Luton and Milton Keynes based on the Joint Strategic Needs Assessments, Health and Wellbeing strategies, Place plans, and the voice of people with lived experience.

8.2 In fulfilling its statutory duty, the Joint Committee's role is to:

- Facilitate joint action to improve health and care outcomes and experiences.
- Influence the wider determinants of health, including creating healthier environments and inclusive and sustainable economies.
- Create a dedicated forum to enhance relationships between the leaders across the health and social care system.
- Build a culture of partnership and broad collaborations to promote and support holistic care.
- Highlight where coordination is needed on health and care issues and challenges partners to deliver the actions required.

9.0 Emergency powers

9.1 Where an urgent decision needs to be made in between scheduled meetings, members of the Joint Committee can convene an extra-ordinary meeting to discuss a particular issue. Quorum rules in paragraph 4 still apply.

9.2 If it is not practicable to meet in person, matters can be dealt with through telephone or the exchange of emails. The exercise of such powers shall be reported, and a minute taken at the next Joint Committee meeting.

10.0 Reporting arrangements to the Board

10.1 The Joint Committee will report to the ICB and the Health and Wellbeing Boards of Bedford Borough Council, Buckinghamshire Council, Central Bedfordshire Council, Luton Borough Council and Milton Keynes Council on a quarterly basis.

11.0 Reporting arrangements of other Committees and Groups

11.1 The Joint Committee has authority to establish committees and groups (below) which will report into the ICP and provide minutes of their meetings:

12.0 Annual review of the Committee

12.1 The Joint Committee will undertake a self-assessment within six months of operating and annually thereafter to:

- Review that these Terms of Reference have been complied with and whether they remain fit for purpose.
- Determine whether its planned activities and responsibilities for the previous year have been sufficiently discharged; and,
- Recommend any changes and / or actions it considers necessary, in respect of the above.
- Provide the ICB, and Health and Wellbeing Boards of Bedford Borough Council, Buckinghamshire Council, Central Bedfordshire Council, Luton Council and Milton Keynes Council with an annual report, which details the outcome of the annual review.

13.0 Committee servicing

13.1 The Joint Committee shall be supported administratively by the Integrated Care Board's Governance team (or other nominated representative), who's duties in this respect will include:

- Agreement of the agenda with the Joint Committee's agenda setting group and collation of papers in-line with the Committee's Annual Cycle of Business.
- Providing written notice of meetings to Joint Committee's members, and the papers, not less than five working days before the meeting.
- Taking the minutes and keeping a record of matters arising and issues to be carried forward.
- Producing a single document to track the Joint Committee's agreed actions and report progress to the Joint Committee.
- Producing draft minutes for approval within five working days of the meeting.

Appendix J – Health and Care Senate Terms of Reference

1.0 Purpose

- 1.1 The Health and Care Senate provides health and care professional leadership and advice to the BLMK ICB, ICP and has a role in ensuring that the health and care professional voice is heard at every level of the Integrated Care System.

2.0 Functions

- Provides impartial health and care advice to the ICB and ICS. For example, on the development of the system population health and care strategy and plans.
- Draws on the skills of its members from diverse health and care backgrounds, independently of organisational base.
- Identifies system health and care priorities to inform Place and Care Alliance work plans.
- Provides links to wider health and care structures; East of England and national clinical and professional bodies to consider local application of external work, drive innovation and apply research.
- Supports the development of the system health and care professional leadership framework and Implementation plan.

3.0 Duties

- Act as an advisory group for health and care professionals across BLMK, taking representation from each health and care professional discipline.
- Ensures health and care professionals are engaged, involved and invested in the vision, purpose and work of the Integrated Care System.
- Provides health and care views on system-wide service transformation proposals or significant changes to clinical models prior to their approval at ICP/ ICB Boards. Linked to Place-based health and care leadership groups, whose purpose and functions align with this group.
- Develops health and care led solutions where appropriate and makes recommendations as required.
- Reviews the potential opportunities for improvement of health and care services across BLMK, based on the agreed Integrated Care System priorities.
- Ensures the system develops robust clinical proposals, being cognisant of safety and effectiveness and that the rationale underpinning financial assumptions are clinically sound.
- Highlights risks regarding quality of care, feeding these into the appropriate risk and quality management systems.
- Recommends evidenced based intervention clinical policies to the Quality and Performance Committee for approval.

4.0 Ways of Working

- Works in an open and transparent way, ensuring the advice it gives is evidence-based and in the best interests of patients.
- Captures system-wide views, knowledge, skills and experience.
- Fosters a culture of collaboration, providing independent health and care strategic advice to Integrated Care System.
- Finds 'system thinkers', innovators, experts and respected leaders within the ranks of health and care professionals.
- Identifies the next generation of health and care professional system leaders.
- Supports other professions to communicate their contribution, so their voice is heard and integrated into the leadership structure.
- Recognises primacy of Place and the principle of subsidiarity: ensuring health and care professionals working alongside communities at Place are heard.
- Supports collaborative approaches to co-production of new leadership initiatives and opportunities, building on current work already in progress.

5.0 Membership

- Chair: ICB Chief Medical Director.
- Deputy Chair: Director of Public Health
- ICB Chief Nurse.
- Representative members: The Group will take representation from each health and care professional discipline (medical, nursing, allied health professionals, pharmacy, public health and social care etc).
- Others as required.
- Members attend the Health and Care Senate representing their respective disciplines / professions, rather than the organisation that employs them.

6.0 Reporting and accountability

- 6.1 The Health and Care Senate will report on activity to the ICB and submit an annual report outlining its work.

7.0 Decision making

- 7.1 The Health and Care Senate may only act in an advisory capacity, and as such has no formal decision-making powers on behalf of the Board of the Integrated Care Board.

8.0 Secretariat and Administration

- 8.1 The Committee shall be supported with a secretariat function which will include ensuring that:
- The agenda and papers are prepared and distributed at least five working

days before each meeting in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Executive lead.

- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not attend at least 75% of meetings..
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues / areas of interest / policy developments.
- Action points are taken forward between meetings and progress against those actions is proactively monitored.

9.0 Quorum

- 9.1 The quorum of the Health and Care Senate is four individuals and must include either the Chair or Deputy Chair.

10.0 Frequency of meetings

- 10.1 The Health and Care Senate will meet a minimum of four times a year.

11.0 Review

- 11.1 The Health and Care Senate will review its effectiveness at least annually.
- 11.2 These Terms of Reference will be reviewed at least every two years and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board of the ICB for approval.

Appendix K – Bedford Borough Council Health and Wellbeing Board and Bedford Borough Place Executive Delivery Group

CONSTITUTION AND TERMS OF REFERENCE OF THE BEDFORD BOROUGH COUNCIL HEALTH AND WELLBEING BOARD

Adopted by Bedford Borough Council on 27 March 2013, amended on 13 March 2024

1. NAME

- 1.1 The name of the Board is “the Bedford Borough Health and Wellbeing Board” (“the Board”) and is established by Bedford Borough Council (“the Borough Council”) under the provisions of section 194 of the Health and Social Care Act 2012 (“the Act”) and section 102 of the Local Government Act 1972.

2. MEMBERSHIP OF THE BOARD

- 2.1 The Board shall consist of the following mandatory and discretionary Members:-

1. the Portfolio Holder for Health and Wellbeing; and/or the Mayor of Bedford Borough Council; and/or one or more members of the Council, nominated by the Mayor to be members of the Board.
2. the Chief Executive of Bedford Borough Council:-
3. the following Directors of Bedford Borough Council:-
 - the Director of Children’s Services
 - the Director of Adults’ Services
 - the Director of Public Health
4. three representatives of the Bedfordshire, Luton and Milton Keynes Integrated Care Board, as follows.
 - The Chief Executive Officer
 - The Place Lead Director for Bedford Borough
 - A Primary Care Clinical Director or GP representative from Bedford Borough;;
5. a representative of Health Watch Bedford Borough.
6. a representative of Bedfordshire Hospitals NHS Foundation Trust;
7. a representative of Cambridgeshire Community Services NHS Trust;
8. a representative of East London NHS Foundation Trust;
9. a representative of Community Voluntary Service .

- 2.2 Substitute members will be permitted, subject to consultation with and the agreement of the appointed Chair of the Board.

- 2.3 The Board may itself appoint additional members at any time where it considers it appropriate to do so. The Council may only appoint additional discretionary members to the Board following consultation with the Board.

3 TERMS OF REFERENCE OF THE BOARD

- 3.1 To exercise the functions of the Council and its partner Integrated Care Board under Sections 116 and 116A of the Local Government and Public Involvement in Health Act 2007.
- 3.2 To encourage persons who arrange for the provision of any health or social care services in the area of Bedford Borough to work in an integrated manner for the purpose of advancing the health and wellbeing of the people in its area.
- 3.3 To provide such advice, assistance or other support the Board thinks appropriate for the purpose of encouraging the making of arrangements under Section 75 of the National Health Service Act 2006 in connection with the provision of such services as are mentioned in (1) above.
- 3.4 To encourage persons who arrange for the provision of any health related services in its area to work closely with the Health and Wellbeing Board.
- 3.5 To encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health related services in its area to work closely together.
- 3.6 To provide the Council with its opinion on whether the Council is discharging its duty under Section 116B of the Local Government and Public Involvement in Health Act 2007.
- 3.7 To undertake any further functions that are exercisable by the Council and are delegated to the Board by a resolution of the Full Council.
- 3.8 In accordance with section 198 of the Health and Social Care Act 2012 and where the Board considers it appropriate to do so, to make arrangements for:-
- (a) any of its functions to be exercisable jointly with one or more other boards;
 - (b) any of its functions to be exercisable by a Joint Sub-Committee of the Boards;
 - (c) a Joint Sub-Committee of the Boards to advise it on any matter related to the exercise of its functions.
- 3.9 For the purpose of enabling or assisting the Board to perform its functions, to request any of the following persons to supply it with such information as may be specified in the request:-

- (a) the Borough Council;
- (b) any person who is represented on the Health and Wellbeing Board by virtue of paragraphs 2.1 above;
- (c) any person who is a member of the Board by virtue of paragraph 2.1 above but is not acting as a representative

provided that the information is to be used by the Board only for the purpose of enabling or assisting it to perform its functions and that the information relates to:-

- (a) a function of the person to whom the request is made; or
- (b) a person in respect of whom a function is exercisable by that person.

(Note:-

“the health service” has the same meaning as in the National Health Service Act 2006;

“health services” means services that are provided as part of the health service in England;

“health related services” means services that are provided in pursuance of the social services functions of Local Authorities (within the meaning of the Local Authority Social Services Act 1970)).

BEDFORD BOROUGH HEALTH AND WELLBEING BOARD

SUPPLEMENTARY PROCEDURE RULES

1 QUORUM MEETINGS AND PROCEEDINGS OF THE BOARD

- 1.1 The quorum for a meeting of the Board shall be 1/4 of the whole number of members of the Board.

2 PUBLIC QUESTIONS

- 2.1 Members of the public may ask questions at the beginning of each meeting in accordance with the Council’s Constitution, but will not otherwise be entitled to address the Board.

3. DISCLOSURES OF INTEREST

- 3.1 All voting Members of the Board shall comply with the Borough Council’s Code of Conduct.
- 3.2 Members of the Board who are not Members or Officers of the Borough Council shall in addition comply with any Code of Conduct applicable to their professional body and/or the organisation they represent in so far as this does

not conflict with the Borough Council's Code of Conduct for Members which, in the case of any conflict, shall prevail.

4. CESSATION OF MEMBERSHIP OF THE BOARD

- 4.1 A Member of the Board who is not either a Councillor or Officer of the Borough Council shall cease to hold office if:-
- (a) He or she notifies to the Board a wish to resign.
 - (b) He or she ceases to be a member, or the appointed representative, of a constituent body.

5 WITHDRAWAL FROM BOARD MEMBERSHIP

- 5.1 The Board is a statutory body with a core membership fixed by statute. Without prejudice to 5.2 below, a member of the Board appointed to the Board under Section 192(2)(g) of the Health and Social Care Act 2012 (*ie: such other persons, or representatives of such other persons, as the Borough Council thinks appropriate and referred to below as a "discretionary member"*) may, by giving notice in writing to the Borough Council's Chief Officer for Legal, Performance and Democratic Services, withdraw from membership of the Board. Where a discretionary member appointed by the Council withdraws from membership of the Board it will be for the Borough Council to determine whether to replace that discretionary Member
- 5.2 The Borough Council may, at any time, terminate the membership of a discretionary Member who it has appointed to the Board.
- 5.3 Without prejudice to paragraph 5.4 below, a member of the Board appointed to the Board under section 194 (2) (8) of the Health and Social Care Act 2012 (i.e an additional person appointed by the Board) and referred to below as an "additional person" may, by giving 2 months' notice in writing to the Borough Council's Chief Officer for Legal, Performance and Democratic Services, withdraw from membership of the Board. Where an additional member withdraws from membership of the Board, it will be for the Board to determine whether to replace that additional member.
- 5.4 The Board may, at any time, terminate the membership of an additional member who it has appointed to the Board.

6 REVIEW OF BOARD CONSTITUTION, TERMS OF REFERENCE AND PROCEDURE RULES

- 6.1 This Constitution, Terms of Reference and Procedure Rules will be reviewed annually by the Board and any proposal for change submitted as a recommendation to the Borough Council via the Council's General Purposes Committee (or any successor thereof).

- 6.2 Any Member of the Board may contribute to that review and submit a proposal for a change to the Constitution for consideration by the Board. Any such proposal must be in accordance with the statutory provisions that apply the Board.

Bedford Borough Place Executive Delivery Group

1. Introduction

The Bedford Borough Place Executive Delivery Group (EDG) is part of the Place based Partnership arrangements for Bedford Borough, reporting to the Health and Wellbeing Board which is the strategic and engagement lead at place. The EDG will also work alongside other tactical delivery groups in the system. The Executive Delivery Group is composed of the main health and social care commissioners and providers in order to undertake collaborative detailed planning and delivery of the Place Based Plan.

The Place Based Plan sets out the shared ambition for the transformation of health and care services in Bedford Borough, focusing on the local opportunities and challenges that require a partnership approach. The shared ambition is that Bedford Borough residents are able to live healthy, thriving lives; that health and care services in the Borough are high quality, good value and designed around people's needs; and, that residents, service users and carers are active and equal partners in their health and care.

2. Purpose of the Bedford Borough Place Executive Delivery Group

- In collaboration with the Bedford Borough Place Based Partnership, to develop the shared ambition for health and care in Bedford Borough.
- To work together to achieve our shared ambition by delivering the transformation objectives in the Place-Based Plan.
- To advocate for the issues that Bedford Borough partners agree can be addressed more effectively through a collaborative approach with other Bedfordshire, Milton Keynes and Luton (BLMK) ICS (Integrated Care System) partners, and where appropriate participate in BLMK-wide plans and work programmes.
- To identify and monitor progress against key actions delivered by other forums that will contribute towards the shared ambition.

3. Values

The Bedford Borough Place Executive Delivery Group will share these values and ways of working:

- Honest, transparent, open culture between partners;
- Each partner to act as a critical friend and hold each other to account;

- Each partner to be open to challenge and change;
- To provide mutual support to enable delivery as a Place-Based Partnership;
- To have a collaborative leadership approach.

4. Key Responsibilities of the Bedford Borough Place Executive Delivery Group

That all members of the Bedford Borough Place Executive Delivery Group are responsible for:

- Overseeing the development and implementation of the Bedford Borough Place Based Plan.
- Reporting to the Bedford Borough Health and Wellbeing Board on progress with the Place Based Plan.
- The identification and delivery of specific actions relating to the objectives of the Place-Based Plan.
- Identifying any duplication or gaps in delivery at place.
- Reporting progress against the actions of the plan, highlighting barriers to progress and working collaboratively to overcome them.
- Organisational aspects of system performance, sharing performance data transparently.
- Working closely with the BLMK Integrated Care Board and the Integrated Care Partnership, where appropriate, to ensure system-wide transformation of health and care services in line with Bedford Borough and BLMK plans.
- Liaison with the Bedfordshire Care Alliance on the BCA delivery of place priorities.
- Considering the best use of resources available, ensuring that they are used to provide cost-effective, high quality, sustainable services.
- Communicating the Executive Delivery Group's plans, actions and outcomes with the wider health and social care sector and the organisations that they represent.

5. Core Membership

Chief Executive and Director-level representation on behalf of organisations as follows:

Organisation	Role
Bedford Borough Council	Chief Executive
	Director of Public Health
	Director of Adult Services
	Director of Childrens Services
NHS BLMK Integrated Care Board	Chief Executive
	Place Based Director
Bedfordshire Hospitals NHS FoundationTrust	Chief Executive
	Chief Operating Officer for Bedford Hospital Site
East London NHS Foundation Trust (ELFT)	Chief Executive
	Director of Community Services (Bedfordshire)

Bedfordshire Care Alliance	Programme Director
Primary Care Networks	Clinical Director (on behalf of Caritas, East Bedford, North Bedford and Unity – 3 month rotation)

To ensure continuity, consistent attendance by the same individual is preferable. Attendance will be reported annually to the Bedford Borough Health and Wellbeing Board

In the event of any of the above being unable to attend, a nominated deputy is entitled to attend in their place and should be able to make decisions on behalf of their organisation. Members are responsible for identifying if their corporate governance requirements requires that a decision needs to be made by another body.

Other individuals may be invited to attend as contributors and observers as and when appropriate. This may include local providers (e.g. Cambridgeshire Community Services, Bedfordshire Care Group), representatives of the ICS, and other local stakeholders.

6. Advisory Roles and Wider Stakeholder Involvement

The Bedford Borough Place Executive Delivery Group may choose to invite key partners and local agencies for specific items where their expertise will be required.

The Group will support the work of the Health and Wellbeing Board in ensuring that wider stakeholders and the public are able to contribute to the development of health and social care.

The Group will also ensure that it is aware of and take account of work done by other key boards and delivery groups in at place, including (but not limited to):-

- Child Health and Wellbeing Officer Group
- Healthy People, Health Places Officer Group
- Health and Social Care Cell and related Delivery Groups
- Better Care Fund Board
- A&E Delivery Board
- Local Authority Partnership Boards

7. Chair

Chair: Chief Executive, Bedford Borough Council

Vice Chair: Chief Executive Officer, BLMK ICS

In the absence of the Chair, the Vice Chair will take responsibility for the meeting. In the absence of both the Chair and Vice Chair, the Place Executive Delivery Group will elect a Chair to take responsibility for that meeting only.

8. Governance

The Bedford Borough Place Executive Delivery Group will report to the Bedford Borough Health and Wellbeing Board and to the BLMK Integrated Care Board at a regular frequency and on request.

The Group has no formal delegated decision making powers and its member organisations are responsible for ensuring that decisions are taken through their appropriate organisational governance processes if required.

9. Quorum

To ensure that the meeting is quorate, the following must be in attendance:

Bedford Borough Council	Chief Executive or Director of Adult Services
BLMK ICB	Chief Executive Officer or Place Based Director
Bedfordshire Hospitals NHS Foundation Trust	Chief Executive or Chief Operating Officer
ELFT (for both mental health and community health services)	Chief Executive or Director
Primary Care Networks	One Clinical Director

It is expected that those members of the Bedford Borough Place Executive Delivery Group unable to send a representative to the meeting will review minutes and actions circulated and take note of any forthcoming action required.

10. Conflicts of Interest

Members of the Bedford Borough Place Executive Delivery Group will be bound by the Standing Orders and Codes of Conduct of their respective organisations. Declarations of interest will be recorded annually and at the start of each meeting. Anything arising in relation to a conflict of interest will be recorded in the minutes.

11. Frequency of meetings:

Meetings will be held every month. Exceptional meetings may be called with prior notice when required.

12. Forward Work Programme and Agendas

Each meeting will consider the work programme for the Bedford Borough Place Executive Delivery Group and agree the next agenda.

Additional requests for agenda items should be submitted in writing to the Administrator including an explanation of the purpose of the item and the action required from the Bedford Borough Place Executive Delivery Group. These additional requests will be included subject to agreement by the Chair.

13. Meeting Administration

Bedford Borough Council

14. Terms of Reference Approved

08-06-2022

15. Review Date:

To be reviewed within the first six months of operation from July 2022.

Appendix L – Central Bedfordshire Place Board

Working collegiately to drive strategy for transformation to improve outcomes for Central Bedfordshire's population.

1.0 Purpose

- 1.1. Central Bedfordshire Place Board brings together senior leaders and partners to provide a collective view of system issues as a 'Place' within the Integrated Care System.
- 1.2. Ensure best use of the total resources available to the partners to meet the specific needs of Central Bedfordshire residents.
- 1.3. Ensure alignment of all age strategic plans and vision across ICS and at Place to deliver integrated outcomes for Central Bedfordshire residents.
- 1.4. Ensure a collaborative approach to addressing local challenges and appropriate use of system-wide flexibilities to deliver solutions that maximise outcomes for residents.
- 1.5. Facilitate strong relationships and leadership to support Primary Care Networks and delivery of priorities at PCN level
- 1.6. Provide a forum for delivery of the 2050 Vision for Central Bedfordshire and reducing inequalities.
- 1.7. Ensure there is a tangible 'place' focused framework for delivery of ICS, Bedfordshire Care Alliance; implementation of the NHS LTP and wider transformation plans.
- 1.8. Advance an all-age population health management approach to understand and predict future health and care needs with Primary Care Networks as essential building blocks.

2. Key Responsibilities

- 2.1. Provide leadership and be the focal point for shaping all-age priorities for Central Bedfordshire and accountability for delivery of BLMK ICS and ICP priorities and plans.

- 2.2. Align priorities and gather intelligence from other relevant strategic planning, ensuring that arrangements for place-based planning are robust and emerging issues are addressed.
- 2.3. Bring together all key partners from across health and social care to coordinate the delivery of evidence-led and targeted local solutions that achieve the priorities and ambitions of the Health and Well Being Board.
- 2.4. Oversee the delivery of timely integrated outcomes for Central Bedfordshire residents and makes best use of available resources.
- 2.5. Have oversight of financial budgets and delegation of teams to deliver transformation at 'Place'.
- 2.6. Maintain oversight for strategic market development and management as well as strategic plans on commissioning services and aligned/pooled resources.
- 2.7. Provide feedback to the Health and Wellbeing Board and Bedfordshire Care Alliance as appropriate on related workstreams.
- 2.8. Work constructively and collaboratively with other key partnerships and agencies as appropriate in relation to the delivery of health and wellbeing outcomes.
- 2.9. Have oversight for place-based delivery, task and finish or implementation groups to take forward work on strategic priorities identified within the strategic planning process for systemwide or place-based initiatives including:
 - Living Well; Ageing and Fairness and Cohesion
 - Integrated Health and Care Hubs Delivery
 - Mental Health and Learning Disabilities Transformation
 - Children, Young People and Families
 - Digital and Data Strategies
 - Anticipatory Care and Urgent Community Response
 - Better Care Fund Plan
 - Workforce Market Sustainability
- 2.10. Provide updates to Health and Wellbeing Board

3. Key areas of focus

- 3.1. Alignment of strategic plans and place vision across primary care, community, mental health and social care to deliver integrated outcomes.

- 3.2. Advance ambitions around joint working; joint commissioning and shared resources – at ‘place’.
- 3.3. Estates – Maximise public assets for local population.
- 3.4. Sustainability of the social care market.
- 3.5. Better Care Fund Plan – use of integrated/pooled funds.
- 3.6. Oversight of Bedfordshire Care Alliance workstreams.
- 3.7. Community Health Services Transformation.
- 3.8. Deliver improvements on key service challenges and access e.g., SEND; Primary Care; Waiting Lists.
- 3.9. Update on implementation of Primary care strategy - at ‘place’.
- 3.10. Mental Health Transformation – operational delivery and outcomes.
- 3.11. Building on the digital. Shift towards digital by default agenda. Implications for digital inclusion.
- 3.12. Workforce – attracting and retaining our workforce – oversight and working alongside People Board.
- 3.13. Review Place Based Population Health data to ensure that performance improvements are in line with Central Bedfordshire’s statistical family groups.
- 3.14. Co-production at place.

4 Core Membership

- Director of Social Care, Health and Housing (CBC)
 - (ICS Link Director)
 - Director of Children’s Services
 - Director of Place and Communities
 - Directors of Provider Services -CHS; CCS; MH; BHBHSFT
 - Director of Public Health
 - PCN Clinical Directors
- 4.1. Core members of the Place Board will be supported by attendees from the representative organisations: BCA and LMC.

4.2. An Advisory Group will be set up and will include wider representation from VCSE across all ages as well as Independent Sector Care Providers. (The Advisory Group will meet quarterly).

- VCSE Leads
- Healthwatch Central Bedfordshire
- Housing
- Finance
- Fire, Police and Ambulance
- Persons with Lived Experience
- Independent care providers

5.0 Key relationships

- Bedfordshire Care Alliance
- Health and Social Care Cell and related Delivery Groups
- Health and Wellbeing Board
- ICB and ICP
- Children's Leadership Board /BLMK Transformation Board
- Healthwatch Central Bedfordshire
- Patient Participation Group
- Overview and Scrutiny Committee
- Primary Care Networks

6.0 Chair and administration

6.1 Director of Social Care, Health and Housing will Chair the Place Board. ICB Place Director will stand as Vice Chair.

- Meeting will be facilitated by Central Bedfordshire Council.

7.0 Frequency of meetings

7.1 Meetings should be held monthly and aligned to other key meetings of the Health and Well Being Board and the appropriate Priority Boards of the BLMK ICS and ICP.

8.0 Quorum

8.1 Central Bedfordshire Place Board will be quorate with a minimum of six partner organisations. CBC; ICB; Acute Trust; CCS; ELFT and PCN

9.0 Substitution – nominated substitute can be made when core member is unable to attend.

10.0 Accountability and Governance

(An organisation chart of reporting group and relationships to be produced).

- Health and Wellbeing Board and will provide updates at each meeting, highlighting any key issues and recommendations for decision making.
- An Annual Report on progress against the Place Plan will be produced
- Minutes of meetings of the Place Board will be of Public record.

11.0 Dispute resolution. [To be added]

12.0 Conflict of Interests [To be added]

Appendix M – Luton At Place Board Terms of Reference

Note: these terms of reference will be updated by the Luton at Place Board after the establishment of the Integrated Care Board

1.0 Purpose

- 1.1 To bring together senior leaders and partners to drive and facilitate partnership working with a common vision and purpose.
- 1.2 Align strategic, All Age - Health and Care plans, including but not exclusive to; Population Wellbeing Strategy, Luton 2040, NHS Long term Plan/5 year At Place Plan and the Luton Recovery Road Map, the Children's Families and Education Plan, to identify, define, agree and drive the delivery of collective priorities for Luton. To strategically shape and direct transformation, to meet the specific needs of Luton population health and wellbeing needs of residents across Integrated Care System (ICS) and at Place.
- 1.3 Ensure a collaborative approach to addressing local challenges and appropriate use of system-wide flexibilities and resources to deliver solutions that maximise outcomes for residents.
- 1.4 Facilitate strong relationships with system partners; the 5 Primary Care Networks, Luton Borough Council, Bedfordshire Hospitals Foundation Trust, VCS organisation's and the BLMK CCG, including the Bedfordshire Care Alliance, as part of the Integrated Care System, to support an understanding of the wider local, regional and national priorities, influencing place decisions.
- 1.5 Embed an all-age approach to ensure children and young people are provide with the best start in life, enabling them to grow up happy, healthy and secure, with a voice that matters and the opportunities they need to thrive throughout their lives. 'Born-Grow-Live-Work-Age'
- 1.6 Collectively champion Luton as a place of aspirations and achievements; a place with people at its heart.
- 1.7 Ensure there is a tangible 'place' focused framework for delivery of the At Place priorities, to reflect the ICS, Population Wellbeing and the Luton 2040 priorities, which will steer the implementation of the NHS LTP and the Luton ambitions.

2.0 Key Responsibilities

- 2.1 Provide leadership and be the focal point for shaping the all-age priorities and plans for Luton and accountability for delivery of the Luton ambitions, against the relevant local, regional and national strategies.
- 2.2 Set ambitions and objectives that are challenging and outcome focused; reflecting the wider determinants of health and wellbeing, preventative and

- proactive service provision, supported by a strengths and assets based foundation, personalisation, an all ages-whole life approach.
- 2.3 Advance a population health management approach to understand and predict future health and care needs as essential building blocks to proactive transformation delivery.
 - 2.4 Align priorities and gather intelligence from all relevant strategic plans, ensuring that arrangements for place-based planning are robust and emerging issues are addressed.
 - 2.5 Bring together all key partners from across health, social care and the voluntary and community sector to coordinate the delivery of targeted local solutions that achieve the at place priorities and the ambitions of the Health and Well Being Board.
 - 2.6 Have oversight for place-based delivery groups and task and finish or project implementation groups tasked take forward work on strategic priorities identified within the strategic planning process for system-wide or place-based initiatives. Including:
 - Frailty and Complex Care (including falls prevention) – oversight on strategic direction, operational delivery and outcomes.
 - Mental Health and Learning Disability Transformation – oversight on strategic direction, operational delivery and outcomes.
 - Building on the digital - shift towards digital by default agenda and implications for digital inclusion.
 - Workforce – attracting and retaining our workforce – oversight and working alongside.
 - Children’s, Families and Education - oversight on strategic direction, operational delivery, interconnectivity for a whole life approach and outcomes.
 - Prevention and early detection of Long Term Conditions and supportive self-management.
 - 2.7 Oversee the delivery of timely collective outcomes for Luton residents.
 - 2.8 Maintain oversight for strategic market development, sustainability and management as well as strategic plans on commissioning services.
 - 2.9 Provide feedback on related workstreams to the Health and Wellbeing Board and when required, wider whole system groups.

3.0 Core Membership

Member	Role
Dr Mark Fowler	Corporate Director Population Wellbeing, Luton Borough Council
Nicky Poulain	Director Primary Care and Executive for Place, NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board
David Carter	Chief Executive, Bedfordshire Hospitals NHS Foundation Trust
Sally Cartwright	Director Public Health, Luton Borough Council
Maud O'Leary	Director Adult Social Care, Luton Borough Council and Luton DASS
Amanda Lewis	Director Children's, Families and Education Services
Phil Turner	Health Watch Luton Chair
Pete Reeves	Service Director, Cambridgeshire Community Services
Dr Nina Pearson	Director of Clinical Transformation
Nicola Monk	Corporate Director Inclusive Economy, Luton Borough Council
<ul style="list-style-type: none"> ▪ Dr Barhey Medics ▪ Dr Charles Esene Oasis ▪ Dr Sanjay Sinha Phoenix Sunrisers ▪ Dr Hayden Williams Hatters Health ▪ Dr Mazhar Hussain E Quality ▪ Dr Nina Pearson Lea Vale 	Senior Representatives from the 6 Luton PCN's
Michelle Bradley (& Nina Wright - deputising)	Director, Bedfordshire and Luton Mental Health and Wellbeing Services, ELFT
Luton VCS Alliance, Caroline Cook	CEO Luton All Women's Centre

4.0 Advisory roles

4.1 Key partners will be called upon to provide specific focus and expertise when the agenda requires.

- 4.2 Proposed Partners with specialist expertise include but are not exclusive to the matrix below. Experts within their specialist field are the critical enablers for the At Place priorities and the One Luton Voice.

Member	Role
VSC Experts/Leads	Voluntary and Community Sector
Director Housing	Luton Borough Council
Finance Representatives	Luton Borough Council and NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board
Population Health Consultant (PHM)	Luton Borough Council
Workforce Lead - Inclusive Economy	Luton Borough Council
Fire, Police and Ambulance Services	Luton Emergency Services
Persons with Lived Experience	Luton Residents

- 4.3 In addition to the critical expertise that will be called upon to guide and support the At Place Board agenda, Members commit to developing a further platform for regular engagement with the voluntary and community sector, to cross-pollinate at place plans and priorities.

5.0 Chair

- 5.1 Corporate Director Population Wellbeing, LBC, will Chair the At Place Board. Director Primary Care and Executive for Place, BLMK CCG will stand as the Vice Chair of the At Place Board.

6.0 Frequency of meetings

- 6.1 Meetings are to be held monthly, reporting into the Health and Wellbeing Board, the BLMK ICS and through the Local Authority Democratic process.

7.0 Quorum, Decision Making and Voting

- 7.1 The At Place Board will be quorate with a minimum of six key partner organisation members present. Please see matrix below.

Member by Title	Organisation
Corporate Director Population Wellbeing	LBC
Director Primary Care	CCG
Chief Executive Bedfordshire Hospital Trust	Acute
Service Director	CCS

Bedfordshire and Luton Mental Health and Wellbeing Services	ELFT
Two PCN Senior Representatives	Luton PCN's

7.2 All partner organisations have agreed the appointment of substitute members or nominated deputies to attend in their absence.

7.3 The Board will require consensus prior to any decisions being taken; consensus will be demonstrated by a show of hands and documented in the Minutes. It is important that, given the nature of the decisions, securing the support from the majority of partners will be critical to the success of this Board. In those circumstances where consensus cannot be reached, the matter will be deferred for further consideration by the parties and will be reconsidered after discussions between the Chair and respective partners.

7.4 Functions outside the decision making scope of the Board, but related to the ambitions set out, will be discussed for information only, with the considerations and any recommendations of the Board formally recorded in the Minutes. Items will then be referred to the relevant partner organisation and decision maker.

8.0 Focus Groups

8.1 Specialist Focus Groups and workshops will be tasked to inform the Boards agenda and decision making, when required. This will include critical support from the voluntary and community sector groups, who are able to bring local expertise and the Luton Voice to the table.

9.0 Dispute resolution

9.1 It is recognised that there is a mutual desire is to reach agreement on any matter by consensus that if this is not reached that matter may not move forward. There will be no formal and binding external arbitration procedure.

9.2 It is agreed that any matter of dispute will be referred for further discussion to the Leader of the Council, Luton Borough Council Chief Executive Officer and BLMK CCG Director before recommendations are referred back to the At Place Board for further consideration.

10.0 Key relationships

- 5 Primary Care Networks and associated Boards.
- Health and Wellbeing Board.
- Bedfordshire Care Alliance.
- Democratic Services.
- Accident and Emergency Delivery Board.
- Health and Social Care Cell and related Delivery Groups.
- Children's Trust Board.
- Luton Joint Strategic Commissioning Group.

- Healthwatch, the VCS Alliance and wider VCS engagement groups.

11.0 Accountability and governance

- 11.1 The Luton At Place Board reports directly to the Health and Wellbeing Board and will provide a summary of progress and performance to each meeting, with key issues and recommendations requiring ratification or decision. An annual report will be produced reporting on progress of delivery of the Population Wellbeing Strategy and the ICS priorities.
- 11.2 The Board will link with the senior management teams in the PCN's, Council, CCG, and local providers as required in relation to the development of policy changes or other decisions that require member or trustee approval.
- 11.3 Any established Operational Subgroups delivering the operational priorities of the Luton Delivery Plan will report directly into the Board.

12.0 Conflict of Interests

- 12.1 The At Place Board will be bound by the Standing Orders/Standing Financial instructions and Codes of Conduct of Partner bodies. Declaration of interests will need to be declared annually and at each meeting in line with the agenda. Depending on the topic under discussion and the nature of the conflict of interest, appropriate action will be taken and recorded in the Minutes.

13.0 Variation

- 13.1 The Partners may agree from time to time to modify, extend or restrict the remit of the At Place Board.
- 13.2 The Terms of Reference will be reviewed in August 2022 or sooner at the request of the Chair or Vice Chair.
- 13.3 Partners may call a Joint Strategic Commissioning Group (JSCG) meeting for relevant partners, when required to address, manage and agree joint contractual and budgetary arrangements between the CCG & LA. The JSCG meeting attendance and purpose will remain as set out in the Joint Strategic Commissioning Group ToR . Please see appendix 1.

14.0 Administration and support

- 14.1 Meeting will be facilitated and administered by Luton Borough Council.

Appendix N – Milton Keynes Health and Care Partnership Board Terms of Reference

Health and Care Partnership Board

Membership: 18

Quorum: 6 (see ToR 10 below)

Frequency of meetings: Four times annually (usually, June, September, December and March)

1. Health and wellbeing boards are a component of the Health and Social Care Act 2012 and are statutory bodies. The Health and Care Partnership fulfils the requirement to have a board. It is constituted as a committee of Milton Keynes City Council as a Partnership Board.

2. The main functions of the partnership are:

a) To ensure local multi-agency health and care strategies are evidence based, preventative, coherent and that our local health and care system is working together effectively.

b) To enter into formal agreement with the BLMK Integrated Care Board (ICB) with regard to any functions delegated to Milton Keynes and to oversee and drive progress.

3. In order to do this the partnership will:

a) Provide system wide strategic leadership and oversight for improving the health and wellbeing of the people of Milton Keynes.

b) Consider any public health issues raised by the Director of Public Health not being addressed elsewhere that require the attention of the partners.

c) Consider any safeguarding issues raised by the Safeguarding Partnership, a multiagency group which exists to co-ordinate the work of partners in relation to safeguarding, challenging and supporting partners to deliver on their statutory safeguarding responsibilities.

d) Keep the BLMK Integrated Care Partnership (ICP) strategic priorities (start well, live well, age well, growth and reducing inequalities) under review, ensuring local action is addressing these.

e) Keep the strengths and needs of the local population under review, identifying any areas where more action is required, and where appropriate feeding this into the BLMK Integrated Care Partnership (ICP).

4. The core membership of the board will be made up of:

a) The Leader of the Council (Chair)

b) BLMK ICB Chair (Vice Chair)

c) BLMK ICB Chief Executive or representative

d) MKCC Chief Executive

e) MKCC Director of Adult Services

f) MKCC Director of Children's Services

g) MKCC Director of Public Health

h) MKUHFT Chief Executive or representative

i) Central and North West London NHS Trust (CNWL) Chief Executive or representative

j) GP representative

k) TVP Area Commander

l) Bucks Fire and Rescue representative

m) South Central Ambulance Service NHS Foundation Trust representative

n) Healthwatch representative

- o) VCS representative (with links to the local Voluntary Sector Alliance)
 - p) MKCC Councillor from each group to include the Portfolio Holder for Adult Services, the Leader of the main opposition group and a representative from the minority opposition party
5. No elected councillor may serve on the partnership and hold a position of Chair of a Milton Keynes City Council scrutiny committee.
 6. The independent safeguarding scrutineer will be in attendance. Other representatives may be invited to join the partnership in an advisory or expert capacity by the Chair.
 7. Meetings will be held in public except where exempt or confidential information is likely to be disclosed, and the meeting or part of the meeting is held in private. The public will usually be able to watch the meetings live on-line via YouTube. As usual, questions from the public should be submitted in advance of the meeting.
 8. Meetings are conducted in accordance with procedural rules applicable to council committees, except where modified by these terms of reference.
 9. Core members are expected to attend in person where possible. Core members (other than councillors) are required to nominate deputies. Councillors, intending to nominate a substitute to attend on their behalf should notify Milton Keynes City Council Democratic Services in writing (which can be by email) before the start time for the meeting.
 10. The quorum for the Board will consist of six members, of whom no more than half will be Councillors. Only core members will have the right to vote. In line with the national regulations on formal local government committee meetings, members not physically present in the room will not be able to have their vote recorded.

Appendix O - ICB Provider Selection Regime (PSR) Review Group Terms of Reference

1. Constitution

- 1.1 The ICB PSR Review Group (the Group) is established by the Integrated Care Board (the Board or ICB) in accordance with its Constitution.
- 1.2 These terms of reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Group and may only be changed with the approval of the Board.
- 1.3 The following ICBs have agreed to set up mirroring Groups within their governance, to support with a pool of independent colleagues providing members for this Group when required. This arrangement is supported by a Memorandum of Understanding and is intended to mitigate against either perceived or direct conflicts of interest from those who have been involved in the original decision and supports an independent majority for reviews by this Group:
 - NHS Mid and South Essex ICB
 - NHS Norfolk and Waveney ICB
 - NHS Bedford, Luton and Milton Keynes ICB
 - NHS Suffolk and North East Essex ICB
 - NHS Cambridgeshire and Peterborough ICB
 - NHS Hertfordshire and West Essex ICB
- 1.4. For the purposes of clarity – where the term Relevant Authority is used within these terms of reference – it means the original ICB that published a notice containing its intention to award the contract to a chosen provider.

2. Authority

- 2.1 The ICB PSR Review Group - is authorised by the Board to:
 1. Consider representations made against intention to award notices process under C, most suitable provider process, competitive process or a modification issued through the use of provisions set out in the Health Care Services (Provider Selection Regime) Regulations 2023 (the Regulations).
 2. The group may call upon the ICBs listed in 1.3 above to substitute their members' when the Relevant Authority does not have sufficient individuals to trigger an independent review and/or the contract is deemed to be of significant reputational risk.
 3. Where a representation is received within the 8 working days of the notice published by the Relevant Authority – with its intention to award the

contract to the chosen provider and observe the standstill period, the Relevant Authority through this group must:

- a. Ensure that the provider is afforded an opportunity to explain or clarify its representation(s) if these are not clear.
 - b. Is expected to provide an indicative timeframe for when the representation might be considered by, and when the provider might reasonably expect a decision to be made.
 - c. Must provide any information requested by the provider that the Relevant Authority is required to keep under the regime as soon as possible, except where this:
 - i. would prejudice the legitimate commercial interests of any person, including the Relevant Authority
 - ii. might prejudice fair competition between providers
 - iii. would otherwise be contrary to the public interest.
 - d. Must review the evidence and information used to make the original decision, taking into account the representations made.
 - c. Must consider whether the representation has merit (e.g., it identifies that the process has not been correctly followed or brings to light information that has a bearing on the decision reached).
4. The provider that made the representations is expected to respond promptly and concisely to questions from the Relevant Authority about the points it has made, and if it cannot respond within a reasonable timeframe then it is expected to provide a justification.
5. Sufficient time and opportunity will be allowed for the provider that made the representations to respond to questions from the Relevant Authority. In the event that the provider fails to respond/communicate, then it is for the relevant authority to decide whether to complete its assessment of the representations and communicate their decision to the provider.
- 2.2 For the avoidance of doubt, in the event of any conflict, the relevant authority's Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the Group being permitted to meet in private.

3. Purpose

- 3.1 Where the ICB PSR Review Group finds that a representation has merit (e.g., it identifies that the process has not been correctly followed or brings to light information that has a bearing on the decision reached), the recommendations reached must be considered by the Relevant Authority over whether this impacts on the intention to award a contract to the selected provider. The Relevant Authority must then decide to:

- enter into a contract or conclude the framework agreement as intended
 - go back to an earlier step in the selection process, either to the start of the process or to where a flaw was identified, rectify this, and repeat that step and subsequent steps
 - abandon the provider selection process.
- 3.2 The Relevant Authority must communicate the decision described above promptly and in writing, to:
- the provider that made the representation
 - the provider to which the Relevant Authority at the beginning of the standstill period to award the contract, or all providers with which the Relevant Authority intended at the beginning of the standstill period to conclude the framework agreement.
- 3.3 If the provider continues to remain unsatisfied about the Relevant Authorities response, the provider may request the NHS England PSR review panel to consider their representation further. They must submit their request through the [PSR website](#) within five working days of receiving the Relevant Authority's decision following the relevant authority's review of their representation. If the provider submits a request for advice from the PSR review panel, the Relevant Authority will be notified, and the relevant authority should:
- keep the standstill period open for the duration of the panel's review.
 - make a further decision once it has considered the independent expert advice.
- 3.4 If the provider does not submit their request to the PSR review panel within the five working day period, or the PSR review panel does not accept the request for advice, then at any point after the end of that period, the Relevant Authority can bring the standstill period to an end and proceed to award the contract to their chosen provider.

4. Membership and Attendance

4.1 Membership

The ICB PSR Review Group members shall be appointed by the Chair of the Group at the time it is required to meet.

The Membership of this ICB PSR Review Group will remain flexible to accommodate varying PSR representation, but will appoint no fewer than three members being independent and not involved in the original decision.

Committee members:

- X (Chair)
- X (Vice Chair)

- X

This may include Members drawn from the ICBs listed in 1.3 above, as required.

4.3 Attendees

Only members of the Group have the right to attend meetings, but the Chair may invite relevant attendees to the meeting as necessary.

Meetings of the Group may also be attended by the following individuals. Such attendees will not be eligible to vote on agreed recommendations:

- X
- X
- X

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

5. Meetings Quoracy and Decisions

The Group will meet in private and as required.

5.1 Quorum

For a meeting to be quorate a minimum of three members are required, including the Chair or Vice Chair.

5.2 Equality diversity and inclusion

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

6. Review

6.1 The Group will review its effectiveness at least annually.

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

Appendix P – Primary Medical Services Contract Holders

The identified eligible Contract Holders in the following table, represent an accurate understanding of the geographical area covered by NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board.

Code	Practice Name	Address	Place
Y00260	Arlesey Medical Centre	Arlesey Medical Centre, High Street, Arlesey, Bedfordshire, SG15 6SN	Central Bedfordshire
E81615	Ashburnham Road Surgery	8 Ashburnham Road, Bedford, MK40 1DS	Bedford
E81617	Ashcroft Practice	Ashcroft Practice, 49 Ashcroft Road, Stopsley, Luton, Bedfordshire, LU2 9AU	Luton
K82054	Ashfield Medical Centre	Ashfield Medical Centre, 1 Perrydown, Wastel Beanhill, Milton Keynes, MK6 4NE	Milton Keynes
E81050	Asplands Medical Centre	Asplands Medical Centre, Wood Street, Woburn Sands, Milton Keynes, Buckinghamshire, MK17 8QP	Milton Keynes
E81632	Barton Hills Medical Group	Whitehorse Vale, Barton Hills, Luton, Bedfordshire, LU3 4AD	Luton
E81003	Bassett Road Surgery	The Surgery, 29 Bassett Road, Leighton Buzzard, Bedfordshire, LU7 1AR	Central Bedfordshire
K82039	Bedford Street Surgery	The Surgery, 4 Bedford St, Bletchley, Milton Keynes, Buckinghamshire, MK2 2TX	Central Bedfordshire
E81005	Bell House Medical Centre	Bell House Medical Centre, 163 Dunstable Road, Luton, Bedfordshire, LU1 1BW	Luton
E81028	Blenheim Medical Centre	Blenheim Medical Centre, 9 Blenheim Crescent, Luton, Bedfordshire, LU3 1HA	Luton
E81064	Bramingham Park Medical Centre	Bramingham Park Medical Centre, Lucas Gardens, Barton Hills, Luton, Bedfordshire, LU3 4BG	Luton
Y02900	Brooklands Health Centre	Unit 3, Brooklands Health Centre, Countess Way, Brooklands, Milton Keynes, MK10 7HN	Milton Keynes
E81048	Bute House Medical Centre	Bute House Medical Centre, Grove Road, Luton, Bedfordshire, LU1 1RW	Luton

Code	Practice Name	Address	Place
E81069	Caddington Surgery	Caddington Surgery, 33 Manor Rd, Caddington, Luton, Bedfordshire, LU1 4EE	Central Bedfordshire
E81013	Castle Medical Practice	Castle Medical Practice, 27 Castle Street, Luton, Bedfordshire, LU1 3AG	Luton
E81030	Cauldwell Medical Centre	Bedford Hospital, Kempston Road, Bedford, MK42 9DJ	Bedford
K82065	Central Milton Keynes Medical Centre	C.M.K Medical Centre, 68 Bradwell Common Boulevard, Milton Keynes, Buckinghamshire, MK13 8RN	Milton Keynes
K82057	Cobbs Garden Surgery	Cobbs Garden Surgery, West Street, Olney, Buckinghamshire, MK46 5QG	Milton Keynes
E81063	Conway Medical Centre	Conway Medical Centre, 49 Westbourne Road, Luton, Bedfordshire, LU4 8JD	Luton
E81046	Dr A Sulakshana & Partners	The Surgery, Hexton Road, Barton-Le-Clay, Bedfordshire, MK45 4TA	Central Bedfordshire
E81612	Drs Mirza Sukhani & Partners	The Surgery, 30 The Green, Hockwell Ring, Luton, Bedfordshire, LU4 9NN	Luton
E81635	Eastgate Surgery	Eastgate Surgery, Eastgate House, 28-34 Church Street, Dunstable, Bedfordshire, LU5 4RU	Central Bedfordshire
K82064	Fishermead Medical Centre	Fishermead Medical Centre, Fishermead Boulevard, Milton Keynes, Buckinghamshire, MK6 2LR	Milton Keynes
E81015	Flitwick Surgery	Highlands, Flitwick, Bedfordshire, MK45 1DW	Central Bedfordshire
E81041	Gardenia and Marsh Farm Practice	Gardenia Surgery, 2A Gardenia Avenue, Luton, Bedfordshire, LU3 2NS	Luton
E81047	Goldington Avenue Surgery	85 Goldington Avenue, Bedford, Bedfordshire, MK40 3DB	Central Bedfordshire
Y00328	Goldington Road Surgery	12 Goldington Road, Bedford, MK40 3NE	Bedford
E81031	Great Barford Surgery	26 Silver Street, Great Barford, Bedfordshire, MK44 3HX	Bedford
E81002	Greensand Surgery	Greensand Surgery, The Health Centre, Oliver St, Ampthill, Bedfordshire, MK45 2SB	Central Bedfordshire

Code	Practice Name	Address	Place
E81012	Greensands Medical Practice	Greensands Medical Practice, Brook End Surgery, Brook End, Potton, Sandy, Bedfordshire, SG19 2QS	Central Bedfordshire
E81007	Harrold Medical Practice	Harrold Medical Practice, Peach's Close, Harrold, Bedford, Bedfordshire, MK43 7DX	Bedford
K82067	Hilltops Medical Centre	Hilltops Medical Centre, Kensington Dr, Great Holm, Milton Keynes, Buckinghamshire, MK8 9HN	Milton Keynes
E81074	Houghton Close Surgery	Houghton Close Surgery, 1 Houghton Close, Ampthill, Bedfordshire, MK45 2TG	Central Bedfordshire
E81027	Houghton Regis Medical Centre	Houghton Regis Medical Centre, Peel St, Houghton Regis, Dunstable, Bedfordshire, LU5 5EZ	Central Bedfordshire
E81036	Ivel Medical Centre	Ivel Medical Centre, Chestnut Avenue, Biggleswade, Bedfordshire, SG18 0RA	Central Bedfordshire
E81038	King Street Surgery	273 Bedford Road, Kempston, Bedford, Bedfordshire, MK42 8QD	Bedford
K82074	Kingfisher Surgery	Kingfisher Surgery, Elthorne Way, Newport Pagnell, Buckinghamshire, MK16 0JR	Milton Keynes
E81045	Kingsbury Court Surgery	Kingsbury Court Surgery, Church Street, Dunstable, Bedfordshire, LU5 4RS	Central Bedfordshire
Y02332	Kingsway Health Centre	Kingsway Health Centre, 385 Dunstable Road, Luton, Bedfordshire, LU4 8BY	Luton
E81052	Kirby Road Surgery	Kirby Road Surgery, 58 Kirby Road, Dunstable, Bedfordshire, LU6 3JH	Central Bedfordshire
E81022	Larksfield Surgery Medical Partnership	Larksfield Surgery, Arleseey Road, Stotfold, Hitchin, Hertfordshire, SG5 4HB	Central Bedfordshire
E81026	Larkside Practice	Churchfield Medical Centre, 322 Crawley Green Road, Luton, Bedfordshire, LU2 9SB	Luton
E81032	Lea Vale Medical Practice	Lea Vale Medical Group, Liverpool Road Health Centre, 9 Mersey Place, Liverpool Road, Luton, LU1 1HH	Luton
E81010	Leagrave Surgery	Leagrave Surgery, 37A Linden Road, Luton, Bedfordshire, LU4 9QZ	Luton

Code	Practice Name	Address	Place
E81044	Leighton Road Surgery	Leighton Road Surgery, 1 Leighton Road, Linslade, Leighton Buzzard, Bedfordshire, LU7 1LB	Central Bedfordshire
E81060	Linden Road Surgery	The Surgery, 13 Linden Road, Bedford, MK40 2DQ	Bedford
E81016	Lister House Surgery	Lister House Surgery, 473-475 Dunstable Road, Luton, Bedfordshire, LU4 8DG	Luton
E81019	London Road Health Centre	The Health Centre, 84-86 London Road, Bedford, Bedfordshire, MK42 0NT	Bedford
E81061	Lower Stondon Surgery	109 Station Road, Lower Stondon, Henlow, Bedfordshire, SG16 6JJ	Central Bedfordshire
E81631	Malzeard Road Practice	2A Malzeard Road, Luton, LU3 1BD	Luton
E81043	Marston Forest Healthcare	Marston Surgery, 59 Bedford Road, Marston Moretaine, Bedford MK43 0LA	Central Bedfordshire
K82631	Milton Keynes Village Surgery	Milton Keynes Village Surgery, Griffith Gate, Middleton, Milton Keynes, Buckinghamshire, MK10 9BQ	Milton Keynes
K82060	Neath Hill Health Centre	Neath Hill Health Centre, 1 Tower Crescent, Neath Hill, Milton Keynes, Buckinghamshire, MK14 6JY	Milton Keynes
E81633	Neville Road Surgery	Neville Road Surgery, 5 Neville Road, Luton, Bedfordshire, LU3 2JG	Luton
K82016	Newport Pagnell Medical Centre	Newport Pagnell Medical Centre, Queens Avenue, Newport Pagnell, Buckinghamshire, MK16 8QT	Milton Keynes
K82032	Oakridge Park Medical Centre	Oakridge Park Medical Centre, 30 Texel Close, Oakridge, Milton Keynes, Buckinghamshire, MK14 6GL	Milton Keynes
E81077	Oliver Street Surgery	The Health Centre, Oliver Street, Ampthill, Bedford, Bedfordshire, MK45 2SB	Central Bedfordshire
K82015	Parkside Medical Centre	Parkside Medical Centre, Whalley Drive, Bletchley, Milton Keynes, Buckinghamshire, MK3 6EN	Milton Keynes
E81076	Pasture's Way Surgery	Pastures Way Surgery, Pastures Way, Lewsey Farm, Luton, LU4 0PF	Luton

Code	Practice Name	Address	Place
E81014	Priory Gardens Surgery	The Health Centre, Priory Gdns, Church Street, Dunstable, Bedfordshire, LU6 3SU	Central Bedfordshire
E81049	Priory Medical Centre	Priory Medical Practice, 48 The Glebe, Clapham, Bedfordshire, MK41 6GA	Bedford
K82027	Purbeck Health Centre	Purbeck Health Centre, Purbeck, Stantonbury, Milton Keynes, Buckinghamshire, MK14 6BL	Milton Keynes
E81029	Putnoe Medical Centre Partnership	Putnoe Medical Practice, 93 Queens Drive, Putnoe, Bedford, Bedfordshire, MK41 9JE	Bedford
E81021	Queens Park Health Centre	Queens Park Health Centre, 23C Carlisle Rd, Queens Park, Bedford, MK40 4HR	Bedford
K82013	Red House Surgery	The Red House Surgery, 241 Queensway, Bletchley, Milton Keynes, Buckinghamshire, MK2 2EH	Milton Keynes
E81057	Saffron Health Partnership	Biggleswade Health Centre, Saffron Road, Biggleswade, Bedfordshire, SG18 8DJ	Central Bedfordshire
E81004	Salisbury House Surgery	Salisbury House Surgery, Lake Street, Leighton Buzzard, Bedfordshire, LU7 1RS	Central Bedfordshire
E81035	Sandy Health Centre	Sandy Health Centre, Northcroft, Sandy, Bedfordshire, SG19 1JQ	Central Bedfordshire
E81024	Sharnbrook Surgery	The Surgery, Templars Way, Sharnbrook, Bedfordshire, MK44 1PZ	Bedford
E81033	Shefford Health Centre	Robert Lucas Drive, Hitchin Road, Shefford, Bedfordshire, SG17 5FS	Central Bedfordshire
Y00561	Shortstown Medical Centre	2 Quantrelle Court, Shortstown, Bedfordshire, MK42 0UF	Bedford
K82025	Sovereign Medical Centre	Sovereign Medical Centre, Sovereign Drive, Pennyland, Milton Keynes, Buckinghamshire, MK15 8AJ	Milton Keynes
K82009	Stony Medical Centre	Stony Medical Centre, Market Square, Stony Stratford, Milton Keynes, Buckinghamshire, MK11 1YA	Milton Keynes
E81006	Stopsley Village Practice	Stopsley Village Practice, 26 Ashcroft Road, Stopsley, Luton, Bedfordshire, LU2 9AU	Luton

Code	Practice Name	Address	Place
E81040	Sundon Medical Centre	142/144 Sundon Park Road, Sundon Park, Luton, Bedfordshire, LU3 3AH	Luton
E81037	The De Parys Group	De Parys Group, 23 De Parys Avenue, Bedford, Bedfordshire, MK40 2TX	Bedford
K82610	The Grove Surgery	The Grove Surgery, Farthing Grove, Netherfield, Milton Keynes, Buckinghamshire, MK6 4NG	Milton Keynes
E81073	The Medici Medical Practice	The Medici Practice, 3 Windsor Street, Luton, Bedfordshire, LU1 3UA	Luton
E81025	The Oakley Surgery	The Oakley Surgery, Addington Way, Off Oakley Road, Luton, Bedfordshire, LU4 9FJ	Luton
K82617	The Stonedean Practice	Stonedean Practice, Market Square, Stony Stratford, Milton Keynes, MK11 1YA	Milton Keynes
Y02463	The Town Centre Practice	14-16 Chapel Street, Luton, Bedfordshire, LU1 2SE	Luton
Y00522	The Village Medical Centre	The Village Medical Centre, Kingswood Way, Gt Denham, Bedford, Bedfordshire, MK40 4GH	Bedford
E81034	Toddington Medical Centre	Toddington Medical Centre, Luton Road, Toddington, Bedfordshire, LU5 6DE	Central Bedfordshire
K82615	Walnut Tree Health Centre	Walnut Tree Health Centre, Blackberry Court, Walnut Tree, Milton Keynes, Buckinghamshire, MK7 7PB	Milton Keynes
K82076	Watling Vale Medical Centre	Watling Vale Medical Centre, Burchard Crescent, Shenley Church End, Milton Keynes, MK5 6EY	Milton Keynes
E81001	Wenlock Surgery	The Surgery, 40 Wenlock Street, Luton, Bedfordshire, LU2 0NN	Luton
K82633	Westcroft Medical Centre	1 Savill Lane, Milton Keynes, MK4 4EN	Milton Keynes
K82059	Westfield Road Surgery	11 Westfield Road, Milton Keynes, MK2 2DJ	Milton Keynes
E81009	West Street Surgery	West Street Surgery, 89 West Street, Dunstable, Bedfordshire, LU6 1SF	Central Bedfordshire
K82026	Whaddon Surgery	25 Witham Court, Milton Keynes, MK3 7QU	Milton Keynes

Code	Practice Name	Address	Place
E81008	Wheatfield Surgery	60 Wheatfield Road, Lewsey Farm, Luton, Bedfordshire, LU4 0TR	Central Bedfordshire
Y06810	Whitehouse Health Centre	Brahaman Way, Whitehouse, Milton Keynes, MK8 1BP	Milton Keynes
K82003	Wolverton Health Centre	Gloucester Road, Milton Keynes, MK12 5DF	Milton Keynes
E81018	Woodland Avenue Practice	Woodland Avenue Practice, 30 Woodland Avenue, Luton, Bedfordshire, LU3 1RW	Luton
Y00560	Wootton Vale Healthy Living Centre	Fields Road, Bedford MK43 9JJ	Bedford

Appendix Q – Scheme of Reservation and Delegation

Decisions and functions reserved to the Board of the Integrated Care Board

The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.

The Board will establish the necessary systems and processes to comply with relevant law and regulations, directions issued by the Secretary of State for Health and Social Care, directions, statutory guidance and advice issued by NHS England and relevant authorities and respond to reports and recommendations made by Healthwatch organisations in the ICB area.

	Decisions and functions reserved to the Board	Reference
The Board	Agree the vision, values, and overall strategic direction (strategy) of the ICB.	
The Board	Agree the area's Joint Forward Plan with partner trusts and foundation trusts to meet the health and healthcare needs of the population (all ages) within their area, having regard to the Partnership's strategy.	NHS Act 20026 s14Z52
The Board	Approve the ICB's annual Operational Plan.	
The Board	Approval of all ICB strategies.	
The Board	Approve arrangements for the discharge of the ICB's statutory commissioning functions.	
The Board	Approve arrangements for joint commissioning with NHS England and / or other ICBs and / or local authorities.	
The Board	Approve Standing Financial Instructions and delegated financial limits.	
The Board	Approve expenditure above delegated financial limits.	
The Board	Ratify any failures to comply with the standing orders / temporary suspension of the standing orders.	
The Board	Approve recommended revenue and capital budgets.	
The Board	Approve variations of allocated annual budgets where that variation has a material impact in the opinion of the Chief Finance Officer.	
The Board	Approve the ICB strategy for corporate support.	

	Decisions and functions reserved to the Board	Reference
The Board	Approve the award of section 256 Grants.	
The Board	Approve the award of section 75 arrangements.	
The Board	Approve requests for change to the ICB's Constitution including Standing Orders and submit to NHS England for approval.	
The Board	Approve arrangements for the ICB for the exercise and delivery of joint or delegated decision-making arrangements.	
The Board	Approve the Scheme of Reservation and Delegation.	
The Board	Receive declarations of interests from Board members.	
The Board	Receive reports from committees.	
The Board	Approve the terms of reference including membership of committees and sub-Committees.	
The Board	Approve the arrangements for the conflict of interest management and standards of business conduct.	
The Board	Agree the individuals or officers authorised to authenticate the company Seal and execute a document on behalf of the ICB by their signature.	Standing Orders, section 6.0
The Board	Create or remove committees, or members of committees, of the Board.	Constitution, section 4.6
The Board	Approve the process for identifying and recruiting the Chief Executive in line with NHS England guidance.	
The Board	Approve the Annual Report and Accounts.	
The Board	Approve internal audit and local counter fraud service arrangements.	
The Board	Approve the appointment of external auditors.	
The Board	Approve arrangements for risk management including risk appetite.	
The Board	Approve arrangements for emergency preparedness, resilience and response.	
The Board	Any actions or activity not otherwise covered in the Scheme of Reservation and Delegation	
The Board	Allocating resources to deliver the Joint Forward Plan and annual Operational Plan across the system, determining what resources should be available to	

	Decisions and functions reserved to the Board	Reference
	meet population need in each place and setting principles for how they should be allocated across services and providers (both revenue and capital). Financial rules will apply to ensure delivery of key national commitments, such as the Mental Health Investment Standard and the primary medical and community health services funding guarantee.	
The Board	Approval of policies not covered elsewhere.	

Decisions and functions delegated by the Board to ICB Committees

Committee	Decisions and functions delegated to the Committee	Reference
Audit and Risk Assurance Committee	Assure systems for internal control.	
Audit and Risk Assurance Committee	Review any failures to comply with the standing orders / temporary suspension of the standing orders.	
Audit and Risk Assurance Committee	Approve arrangements for the Information Governance Management Framework.	Data and Security Protection Toolkit
Audit and Risk Assurance Committee	Agree the external auditor fee following recommendation of 'market value' by the Chief Finance Officer'.	
Finance and Investment Committee	Approve arrangements for the discharge of the ICB's statutory financial duties.	NHS Financial Framework: ICB and System Business Finance Rules.
Finance and Investment Committee	Ratify proposals for the acquisition or disposal of property.	
Finance and Investment Committee	Approval of strategic investment to business cases when seeking additional budget outside approved annual allocation.	
Finance and Investment Committee	Approve the agreement and monitoring of the annual Procurement Plan.	
Finance and Investment Committee	Approve banking arrangements.	
Primary Care Commissioning and Assurance Committee	Exercise clinical commissioning decisions as they relate to primary care.	
Primary Care Commissioning and Assurance Committee	Decisions to procure primary care contracts.	

Committee	Decisions and functions delegated to the Committee	Reference
Quality and Performance Committee	Approval of the process for undertaking equality and quality impact assessments and assurance of any associated risks from individual assessments.	
Quality and Performance Committee	Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.	NHS Act 2006, s14Z34
Quality and Performance Committee	Agree and monitor delivery of remedial action plans in respect of significant system performance issues, and escalate to the Board as appropriate.	
Quality and Performance Committee	Approve arrangements for managing individual funding requests.	
Quality and Performance Committee	Approve arrangements for statutory consultation and / or engagement in relation to proposed service change.	
Remuneration Committee	Determine the terms and conditions, remuneration and travelling or other allowances for Board members and ICB employees, including pensions and gratuities, and adopting on establishment national pay frameworks, e.g., Agenda for Change.	
Remuneration Committee	Approve all individual employee compensation or special severance payments.	

Decisions and functions delegated by the Board to other statutory bodies

Body	Decisions and functions delegated to the body	Legal power	Governing arrangements
Bedford Borough Council	Section 75 Arrangements Section 256 Grant.	NHS Act 2006	Partnership Agreements
Central Bedfordshire Council	Section 75 Arrangements Section 256 Grant.	NHS Act 2006	Partnership Agreements
Luton Borough Council	Section 75 Arrangements Section 256 Grant.	NHS Act 2006	Partnership Agreements
Milton Keynes Council	Section 75 Arrangements Section 256 Grant.	NHS Act 2006	Partnership Agreements

Decisions and functions delegated by the Board to individual Board members and employees including Groups

Individual Board member, employee or group	Decisions and functions delegated to the individual or group	Reference
All Executive Directors	Identify and manage principal and emerging risks.	
All Executive Directors	Approve contracts in line with delegated financial authority.	
Chair	Appoint and remove the Board of the Integrated Care Board's Deputy Chair.	
Chair	Appoint a Chief Executive subject to guidance prescribed by NHS England.	
Chair	Approves the appointment of the ordinary Board members.	
Chief Executive	Makes the appointment of the ordinary Board members.	
Chair and Chief Executive	Exercise the powers of the Board in an emergency or for very urgent matters.	
Chief Executive	Appoint and dismiss employee members of the Board.	
Chief Executive	Lead for having regard to the effect of decisions.	
Chief Executive	Approve delegation agreements from NHS England.	
Chief Executive and Chief Finance Officer	Approve losses and special payments in line with ICB delegated limits.	ICB Losses & Special Payments Policy and NHSE guidance
Chief Executive and Chief Finance Officer	Approve organisational structures in accordance with establishment control and operational budget.	
Chief Finance Officer	Lead for financial duties.	
Chief Finance Officer	Approve arrangements for funds held on trust.	
Chief Finance Officer	Recommend budgets to the Board.	
Chief Finance Officer	Leading system-wide work to propose the allocation of resources to deliver the Joint Forward Plan, working within the agreed financial framework ensuring the delivery of national commitments such as the Mental Health Investment Standard and the primary medical and community health services funding guarantee.	

Individual Board member, employee or group	Decisions and functions delegated to the individual or group	Reference
Chief Finance Officer	Leading joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability.	
Audit & Risk Assurance Committee Chair	Conflict of Interest Guardian	
A Non-Executive Member as agreed by the Board	Wellbeing Guardian	
A Non-Executive Member as agreed by the Board	Freedom to Speak Up Guardian	
Chief Medical Director	Caldicott Guardian	
Chief Finance Officer	Senior Information Risk Owner	
Chief of Staff	Accountable Emergency Officer	
Chief Medical Director	Using joined-up data and digital capabilities to drive clinical pathway transformation, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes.	
Chief Medical Director or Chief Nurse	Approval of all full equality impact assessments following initial screening.	
Chief Medical Director	Lead for obtaining appropriate advice (prevention, diagnosis and treatment of illness) and the protection and improvement of public health.	
Chief Medical Director	Lead for promoting and using research.	
Chief Medical Director / Chief Digital and Information Officer	Leading system-wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care.	
Chief Digital and Information Officer	Making decisions in relation to the management of the HBL ICT Shared Services Agreement and its associated Schedules.	

Individual Board member, employee or group	Decisions and functions delegated to the individual or group	Reference
Chief Digital and Information Officer	Have authority to bind their member organisation to any decision taken by the HBL ICT Stakeholder Board.	
Senior Information Risk Owner	Approve arrangements for the Information Governance Management Framework.	
Senior Information Risk Owner	Approval of all full data protection impact assessments following initial screening.	
Head of Information Governance	Data Protection Officer	
Chief Nurse	Lead for improving the quality of clinical services including responsibilities relating to the Patient Safety Incident Response Standards.	Patient Safety Incident Response Framework - Oversight Roles and Responsibilities
Chief Nurse	Review, scrutinise and sign off Quality Accounts from providers on behalf of the ICB.	Regulation 8, NHS (Quality Accounts) Regulations 2010
Chief Nurse	Lead for: <ul style="list-style-type: none"> ▪ Children & young people (aged 0-25), ▪ Transforming care, ▪ Local Maternity & Neonatal System, ▪ Children and young people with special educational needs & disabilities (SEND), ▪ Safeguarding (all age) including looked after children and care leavers, ▪ Down Syndrome (all-age), ▪ Learning disabilities and SRO for LeDeR programme, ▪ Infection prevention and control. 	
Chief Medical Director or Chief Nurse	Approval of all Quality Impact Assessments.	
Chief of Primary Care	Primary medical services functions delegated by NHS England.	Delegation Agreement in respect of Primary Medical Services between NHS England and NHS

Individual Board member, employee or group	Decisions and functions delegated to the individual or group	Reference
		Bedfordshire, Luton and Milton Keynes Integrated Care Board
Chief of Primary Care	Leadership responsibility for: (a) putting contracts and agreements in place to secure delivery of the joint forward plan by primary medical services providers b) supporting the development of primary care networks (PCNs) as the foundations of out-of-hospital care and building blocks of place-based partnerships, including through investment in PCN management support, data and digital capabilities, workforce development and estates.	
Accountable Emergency Officer	Planning for, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England.	Civil Contingencies Act 2004
Chief of Strategy and Assurance	Responsible for ensuring legal requirements are met in respect of public involvement and consultation.	
Chief People Officer	Approve all proposals for action on employment related litigation against or by the ICB including recommending the approval of settlements by the CEO or CFO.	
Chief of Strategy and Assurance	Approve all proposals for action on non-employment related litigation against or by the ICB, including recommending the approval of settlements by the CEO or CFO.	
Chief of Strategy and Assurance	Establishing joint working arrangements with partners that embed collaboration as the basis for delivery of the joint forward plan.	
Chief of Strategy and Assurance	Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations.	

Individual Board member, employee or group	Decisions and functions delegated to the individual or group	Reference
Chief of Strategy and Assurance	Responsibility for ensuring the Accessible Information Standards are met.	Accessible Information Specification (DCB1605)
Chief People Officer	Leading system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers.	
Chief People Officer	Leading the development of and maintenance of standards in the people profession.	
Chief Nurse	Lead for reducing inequalities	
Chief Operating Officer	Leading system-wide work to develop the joint forward plan to meet the health and healthcare needs of the population (all ages) within their area, having regard to the Partnership's strategy.	
Chief Operating Officer	Specialised commissioning functions to be delegated by NHS England.	
Chief Operating Officer	Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes.	
Chief Operating Officer	Lead joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in achieving wider goals of social and economic development and environmental sustainability.	
Chief Operating Officer	Leadership responsibility for arranging for the provision of health services in line with the allocated resources across the ICS through a range of activities including: (a) putting contracts and agreements in place to secure delivery of the joint forward plan by providers (b) convening and supporting providers (working both at scale and at place) to lead major service transformation programmes to achieve agreed outcomes	

Individual Board member, employee or group	Decisions and functions delegated to the individual or group	Reference
	(c) working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care	
Chief Operating Officer	Specialised services functions delegated by NHS England	Delegation Agreement between NHS Bedfordshire, Luton and Milton Keynes and NHS England in relation to Specialised Commissioning Functions
Place-Based Link Executives	Executive director leads for working with place partners on behalf of the ICB and having regard to local assessments and strategies for: <ul style="list-style-type: none"> ▪ Bedford Borough ▪ Central Bedfordshire ▪ Luton ▪ Milton Keynes 	
Executive Team	The approval of business cases	
Operational Group	Approve organisational policies on behalf of the Executive Team	
Exceptional Cases Panel	Individual funding request decisions	Individual Funding Request (IFR) Policy
Health and Care Senate	Recommends evidenced based intervention clinical policies to the Quality and Performance Committee for approval	
System Oversight and Assurance Group	Provide oversight on the delivery of performance and standards, key system programmes, enabling mutual accountability and providing assurance to the Board. The Group has no specific delegated powers for decision-making but shall establish system leadership and partner groups to ensure the delivery of the system plan	Memorandum of Understanding with NHS England

Individual Board member, employee or group	Decisions and functions delegated to the individual or group	Reference
Place-Based Link Executives	Approval and signing Signing of Place Better Care Fund agreements, following a review of the submission by the ICB Executive Team and appropriate place based governance	Board decision 19 July 2024

Decisions and functions delegated to the Integrated Care Board by other organisations

Body making the delegation	Decisions and functions delegated to the individual	Reference
NHS England	(i) Primary medical services (ii) Primary dental services and prescribed dental services (iii) Primary ophthalmic services (iv) Pharmaceutical services and local pharmaceutical services	Delegation Agreement
NHS England	Functions related to the delegation of specialised services.	Delegation Agreement

Decisions and functions reserved to NHS England

NHS England	Appoint and Remove the Chair of the Board	Subject to approval of the Secretary of State for Health and Social Care
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Annex A

Detailed Operational / Financial Scheme of Delegation

Ref	Matter Delegated	Delegated to
A	Revenue Spend Continuing healthcare (CHC – Adult & Children’s) & Special Packages - MH/LD & Autism including S117/Specialist Placements approval (weekly limits)	
	Package approval - to £1,500 per week	CHC / S117 / Specialist Placements Team (Band 8a)
	Package approval – to £2,500 per week	CHC / S117 / Specialist Placements Team (Band 8b)
	Package approval - to £4,000 per week	CHC / S117 / Specialist Placements Team (Band 8c)
	Package approval - to £6,500 per week	Band 8d or above
	Package approval - to £10,000 per week	Executive director
	Package approval - above £10,000 per week	Chief Executive and Chief Finance Officer (jointly)
B	Individual Funding Requests (On the advice of the Exceptional Cases Panel)	
	Package approval - up to £50k	Deputy or Associate Director (Band 8d)
	Package approval - up to £100k	Chief Operating Officer or Chief Medical Director
	Package approval - above £100k	Chief Finance Officer or Chief Executive Officer (jointly)
C	Authorisation of invoices (in Oracle) - relating to commissioning healthcare expenditure under service level agreements, contracts or partnership agreements. This may include non-commissioning expenditure included within NHS contracts - where this is the case, ensure appropriate approval from the relevant Budget Holder as well as the below.	

Ref	Matter Delegated	Delegated to
	In line with budget management responsibilities (i.e. delegated budgets) and subject to quoting and tendering requirements.	
	<p><u>Corporate / Non-Healthcare related Invoices</u></p> <p>Limits for invoice approvals, includes professional services e.g. legal advice, specialist advice, specific projects (all values are inclusive of VAT irrespective of whether this is reclaimable or not):</p>	
	<u>To £10,000</u>	Band 8c
	to £25,000	Associate and deputy directors (Band 8d and above)
	to £100,000	Executive directors
	to £250,000	Chief Operating Officer, Director of Contracting, Deputy CFO
	to £1,000,000	CFO
	Greater than £1,000,000	Chief Executive
	<u>Commissioned Healthcare Invoices</u>	
	to £25,000	Contract Manager (Band 8a)
	to £50,000	Senior manager (Band 8b and above)
	to £200,000	Senior manager, associate director (Band 8c)
	to £5,000,000	Associate Director, deputy director (Band 8d and above)
	to £25,000,000	Executive director, director or deputy CFO

Ref	Matter Delegated	Delegated to
	to £50,000,000	CFO or Chief Operating Officer
	Greater than £75,000,000	Chief Executive
	<u>Continuing Healthcare / S117 / Specialist Placement invoices:</u> <i>It is not anticipated that invoice values will exceed the limits detailed below:</i>	
	to £5,000	Band 8a (CHC / Mental Health Teams)
	to £10,000	Band 8b (CHC / Mental Health Teams)
	to £50,000	Band 8c (CHC / Mental Health Teams)
	to £100,000	Associate director
	to £250,000	Chief Operating Officer
D	Signing of Contracts <i>Signing of contracts, including contract variations and letters of intent (the below is based on the lifetime value of the contract).</i>	
	<u>Non-Healthcare Contracts:</u> to £100,000	Executive director, Director of Commissioning, Director of Contracting, Deputy Chief Finance Officer
	to £500,000	CFO
	to £1,000,000	Chief Executive
	Greater than £1,000,000	Chief Executive & CFO (jointly)

Ref	Matter Delegated	Delegated to
	<u>Healthcare Contracts:</u> to £25,000,000	Executive director, Director of Commissioning, Director of Contracting
	to £100,000,000	CFO or Chief Operating Officer
	to £500,000,000	Chief Executive
	Greater than £500,000,000	Chief Executive & CFO (jointly)
E	Off-payroll / agency workers <i>Non-clinical agency roles are subject to NHS England controls and will need to be approved by the NHS England Regional Team</i>	
	Approval requirements to appointment off-payroll and agency workers: Less than £400 per day and less than three months engagement	Executive director <i>Non-clinical agency subject to NHSE approval</i>
	Less than £600 per day and less than six months engagement	Executive Management Team <i>Non-clinical agency subject to NHSE approval</i>
	Less than £600 per day and greater than six months (including where initial arrangements were for less than six months and have then been extended to greater than 6 months)	Executive Management Team <i>Non-clinical agency subject to NHSE approval</i>
	More than £600 per day	Executive Management Team <i>Non-clinical agency subject to NHSE approval</i>
	Authority to appoint staff not on the formal establishment	Chief Executive & CFO (jointly)

Ref	Matter Delegated	Delegated to
F	Consultancy Expenditure <i>Consultancy is subject to NHS England controls</i>	
	Approval requirements for consultancy spend: to £49,999	Executive Management Team
	£50,000 and above	Executive Management Team plus NHS England approval
G	Emergency Response	
	The Department of Health and Social Care defines a major incident as “an event or a situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK.”	The Tier 1 On Call Manager and the Tier 2 On Call Manager have delegated authority to make urgent financial decisions relating to the ICB within the health community as appropriate during a major incident.
H	Capital Expenditure (ICB Only)	
	These limits relate to capital expenditure incurred by the ICB on behalf of NHS England in respect of information technology for GP practices (GP IT) and Primary Care Estates and ICB Corporate Capital. Capital Business Cases relating to GP IT and Primary Care Estates currently require counter approval by NHS England via the East of England Regional Capital & Investment Oversight Group (CIOG)	
	Up to the ICB Capital Resource Limit as designated by NHS England	Chief Executive or Chief Finance Officer following approval of the annual capital plan by the Integrated Care Board (following recommendation by the Finance & Investment Committee)
I	Tendering and Contracting	

	<p>Limits for quotes and tenders (all values are inclusive of VAT irrespective of whether this is reclaimable or not and apply to the total contract duration).</p> <p>The ICB</p> <ul style="list-style-type: none"> ▪ Will ensure proper competition that is legally compliant within all purchasing to ensure we incur only budgeted, approved and necessary spending ▪ Will seek value for money for all goods and services 	
	<p><u>NON-HEALTHCARE CONTRACTS</u></p>	
	<p>£10,000 to £20,000</p>	<p>A minimum of 2 written competitive quotations must be obtained for:</p> <ul style="list-style-type: none"> ▪ all building and engineering works, ▪ goods, ▪ equipment, and ▪ services <p>Managers are required to hold evidence of quotations for audit.</p> <p>While no formal process is required although best value for money should be sought at all times and purchases should be from a reputable source.</p>
	<p>£20,001 to £50,000</p>	<p>A minimum of 3 written competitive quotations to be obtained for</p> <ul style="list-style-type: none"> ▪ all building and engineering works, ▪ goods, ▪ equipment, and ▪ services <p>Managers are required to hold evidence of quotations for audit.</p>

		While no formal process is required although best value for money should be sought at all times and purchases should be from a reputable source.
	£50,001 and above, but below the Public Contract Regulation Thresholds	If expenditure is likely to exceed £50,000 a formal tendering process must be followed in accordance with the ICB Procurement Policy. If there is a valid reason for not following the formal process (see list of exemptions below) a Single Tender Waiver request form must be completed.
	Equal to or above the Public Contract Regulation Threshold applicable at the time	Compliance with the Public Contract Regulations 2015. Advice to be sought from the Chief Operating Officer and Procurement Advisors.
<p><u>HEALTHCARE CONTRACTS</u></p> <p><i>Formal tendering procedures need not apply where estimated expenditure does not or is not reasonably expected to exceed £250,000 over the whole life of the contract.</i></p>		
	£10,000 to £20,000	A minimum of 2 written competitive quotations must be obtained. Managers are required to hold evidence of quotations for audit. While no formal process is required although best value for money should be sought at all times and purchases should be from a reputable source.
	£20,001 to £50,000	A minimum of 3 written competitive quotations to be obtained. Managers are required to hold evidence of quotations for audit. While no formal process is required although best value for money should be sought at all times and purchases should be from a reputable source.

<p>£50,001 to £250,000</p>	<p>A minimum of 5 written competitive quotations to be obtained (although it is recognised that these may not all be returned).</p> <p>Managers are required to hold evidence of quotations for audit.</p> <p>While no formal process is required although best value for money should be sought at all times and purchases should be from a reputable source.</p>
<p>£250,001 to Public Contract Regulation Threshold (applicable at the time)</p>	<p>For expenditure exceeding £250,000 and below the Public Contract Regulation Threshold (as applicable at the time) - a formal, proportionate and transparent process should be agreed with procurement advisors and carried out in accordance with the ICB Procurement Policy. If there is a valid reason for not following the formal process (see list of exemptions below) a Single Tender Waiver request form must be completed.</p>
<p>Equal to or above the Public Contract Regulation Threshold (applicable at the time)</p>	<p>If expenditure is likely to exceed the Public Contract Regulation Threshold (as applicable at the time), a formal tendering process must be followed in accordance with the ICB Procurement Policy. If there is a valid reason for not following the formal process (see list of exemptions below) a Single Tender Waiver request form must be completed.</p>

Exceptions and instances where formal tendering need not be applied

Formal tendering procedures need not be applied where:

- estimated expenditure does not or is not reasonably expected to exceed £10,000 over the whole life of the contract.(however value for money should be demonstrated)
- where the supply is proposed under special arrangements negotiated by the Department of Health or NHS England in which circumstance such special arrangements must be complied with

Formal tendering procedures may be waived by the prior joint agreement of the Chief Executive and the Chief Finance Officer in the following circumstances:

- (a) Where the Chief Executive or Chief Finance Officer decides that formal tendering procedures would not be practicable, the estimated expenditure or income would not warrant formal tendering procedures.
- (b) where the requirement is covered by an existing contract.
- (c) where NHS Supply Chain are in place and have been approved by the Board of the ICB.
- (d) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members.
- (e) where the timescale genuinely precludes competitive tendering – note that failure to plan properly shall not be regarded as a justification for a single tender.
- (f) where specialist expertise is required but is only available from a single source.
- (g) when the task is essential to complete a project, and arises as a consequence of a recently completed assignment and engaging different contractors for the new task would be inappropriate.
- (h) when there is a clear benefit to be gained from maintaining continuity with an earlier project – in such cases the benefits of such continuity must demonstrably outweigh any potential financial advantage to be gained by competitive tendering.
- (i) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the ICB is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and is generally recognised as having sufficient expertise in the area of work for which they are commissioned (the CFO shall ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work).
- (j) where allowed and provided for in the Capital Investment Manual.

The waiving of competitive tendering procedures shall not be used to avoid competition or for administrative convenience, or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate ICB record and formally reported to the Audit & Risk Assurance Committee.

The Director of Contracting will issue documentation to be used to request any waiver under this clause, and record approval thereof.

Appendix R – Standing Financial Instructions

1.0 Purpose and statutory framework

- 1.1 These Standing Financial Instructions (SFIs) shall have effect as if incorporated into the Integrated Care Board's (ICB) Constitution. In accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022, the ICB must publish its Constitution.
- 1.2 In accordance with the Act as amended, NHS England is mandated to publish guidance for ICBs, to which each ICB must have regard, in order to discharge their duties.
- 1.3 The purpose of this governance document is to ensure that the ICB fulfils its statutory duty to carry out its functions effectively, efficiently and economically. The SFIs are part of the ICB's control environment for managing the organisation's financial affairs as they are designed to ensure regularity and propriety of financial transactions.
- 1.4 SFIs define the purpose, responsibilities, legal framework and operating environment of the ICB. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services.
- 1.5 The ICB is established under Chapter A3 of Part 2 of the National Health Service Act 2006, as inserted by the Health and Care Act 2022 and has the general function of arranging for the provision of services for the purposes of the health services in England in accordance with the Act.
- 1.6 Each ICB is to be established by order made by NHS England for an area within England, the order establishing an ICB makes provision for the Constitution of the ICB.
- 1.7 All members of the ICB (its Board) and all other Officers should be aware of the existence of these documents and be familiar with their detailed provisions. The ICB SFIs will be made available to all Officers on the intranet and internet website for each statutory body.
- 1.8 Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the Chief Executive or the Chief Finance Officer must be sought before acting.
- 1.9 Failure to comply with the SFIs may result in disciplinary action in accordance with the ICBs applicable disciplinary policy and procedure in operation at that time.

2.0 Scope

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

- 2.2 Within this document, words imparting any gender include any other gender. Words in the singular include the plural and words in the plural include the singular.
- 2.3 Any reference to an enactment is a reference to that enactment as amended.
- 2.4 Unless a contrary intention is evident, or the context requires otherwise, words or expressions contained in this document, will have the same meaning as set out in the applicable Act.

3.0 Roles and Responsibilities

Staff

1.1.1 3.1 All ICB Officers are severally and collectively, responsible to their respective employer(s) for:

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

Accountable Officer

- 3.2 The ICB Constitution provides for the appointment of the Chief Executive by the ICB Chair. The Chief Executive is the Accountable Officer for the ICB and is personally accountable to NHS England for the stewardship of ICBs allocated resources.
- 3.3 The Chief Finance Officer reports directly to the ICB Chief Executive Officer and is professionally accountable to the NHS England regional finance director.
- 3.4 The Chief Executive will delegate to the Chief Finance Officer the following responsibilities in relation to the ICB:
- Preparation and arranging the 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).
- Advising the Board of the financial targets set for it by NHS England and the need to meet those targets.
- Using incidental powers such as management of ICB assets, entering commercial agreements
- Ensuring the Governance statement and annual accounts and reports are signed.
- Ensuring planned budgets are approved by the relevant Board; developing the funding strategy for the ICB to support the Board in achieving ICB objectives, including consideration of Place-Based budgets.
- Making use of benchmarking to make sure that funds are deployed as effectively as possible.
- Notifying executive members (partner members and non-executive members) and other officers of, and understand, their responsibilities within the SFIs.
- Ensuring specific responsibilities and delegation of authority to specific job titles are confirmed.
- Financial leadership and financial performance of the ICB.
- Identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions; and,
- Supporting a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risk.

Audit and Risk Assurance Committee

3.5 The Board and Accountable Officer are supported by an Audit and Risk Assurance Committee, which provides proactive support to the Board in advising on:

- The management of key risks.
- The strategic processes for risk.
- The operation of internal controls.
- Control and governance and the governance statement.
- The accounting policies, the accounts, and the annual report of the ICB.
- The process for reviewing of the accounts prior to submission for audit, management's letter of representation to the external auditors; and the planned activity and results of both internal and external audit.

4.0 Management accounting and business management

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

- 4.2 The Chief Finance Officer will delegate the budgetary control responsibilities to budget holders through a formal documented process.
- 4.3 The Chief Finance Officer will ensure:
- The promotion of compliance to the SFIs through an assurance certification process.
 - The promotion of long-term financial health for the NHS system (including ICS).
 - Budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for.
 - The improvement of financial literacy of budget holders with the appropriate level of expertise and systems training.
 - That the budget holders are supported in proportion to the operational risk; and,
 - The implementation of financial and resources plans that support the NHS Long term plan objectives.
- 4.4 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 so as to secure that its expenditure does not exceed the aggregate of its allotment from NHS England and its other income; and,
 - The duty of the ICB, in conjunction with its partner trusts, to seek to achieve any joint financial objectives set by NHS England for the ICB and its partner trusts.
- 4.5 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.

5.0 Income, banking arrangements and debt recovery

Income

- 5.1 The 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.
- 5.2 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 the ICB and the prevailing risks.

Banking

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

5.4 The Chief Finance Officer will ensure that:

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

Debt management

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

5.6 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 Board every 12 months to ensure relevance and provide assurance.
- Accountability to the 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.

6.0 Financial systems and processes

Provision of finance systems

6.1 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 the ICB.

6.2 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.

6.3 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.

6.4 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 ICB are recorded as soon as, and as accurately as, reasonably practicable.
- Ensure publication and implementation of all ICB business rules and ensure that the internal finance team is appropriately resourced to deliver all statutory functions of the ICB.
- Ensure that risk is appropriately managed.
- Ensure identification of the duties of officers dealing with financial transactions and division of responsibilities of those officers.
- Ensure the ICB has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the ICB.
- Ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes; and,
- Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

7.0 Procurement and purchasing

Principles

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

- 7.2 The ICB must ensure that procurement activity is in accordance with the Public Contracts Regulations 2015 (PCR) and associated statutory requirements whilst securing value for money and sustainability.
- 7.3 The ICB must consider, as appropriate, any applicable NHS England guidance that does not conflict with the above.
- 7.4 The ICB must have a Procurement Policy which sets out all of the legislative requirements.
- 7.5 All revenue and non-pay expenditure must be approved, in accordance with the ICB business case policy, prior to an agreement being made with a third party that enters a commitment to future expenditure.
- 7.6 All officers must ensure that any conflicts of interest are identified, declared and appropriately mitigated or resolved in accordance with the ICB Conflicts of Interest Management and Standards of Business Conduct Policy.
- 7.7 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.
- 7.8 Undertake any contract variations or extensions in accordance with Public Contracts Regulations 2015 and the ICB procurement policy.
- 7.9 Retrospective expenditure approval should not be permitted. Any such retrospective breaches require approval from any Committee responsible for approvals before the liability is settled. Such breaches must be reported to the Audit and Risk Assurance Committee.

8.0 Staff costs and staff related non pay expenditure

Chief People Officer

- 8.1 The Chief People Officer will lead the development and delivery of the long-term people strategy of the ICB ensuring this reflects and integrates the strategies of all relevant partner organisations within the Integrated Care System.
- 8.2 Operationally the Chief People Officer will be responsible for:
 - Defining and delivering the organisation's overall human resources strategy and objectives; and,
 - Overseeing delivery of human resource services to ICB employees.

- 8.3 The Chief People Officer will ensure that the payroll system has adequate internal controls and suitable arrangements for processing deductions and exceptional payments.
- 8.4 Where a third-party payroll provider is engaged, the Chief People Officer shall closely manage this supplier through effective contract management.
- 8.5 The Chief People Officer is responsible for management and governance frameworks that support the ICB employees' life cycle.

9.0 Annual reporting and Accounts

- 9.1 The Chief Finance Officer will ensure, on behalf of the Accountable Officer and Board of the ICB, that:
- The ICB is in a position to produce its required monthly reporting, annual report, and accounts, as part of the setup of the organisation; and,
 - The ICB, in each financial year, prepares a report on how it has discharged its functions in the previous financial year.
- 9.2 An annual report must, in particular, explain how the ICB has:
- Discharged its duties in relating to improving quality of services, reducing inequalities, the triple aim and public involvement.
 - Review the extent to which the Board has exercised its functions in accordance with its published five year forward plan and capital resource use plan; and,
 - Review any steps that the Board has taken to implement any joint local health and wellbeing strategy.
- 9.3 NHS England may give directions to the ICB as to the form and content of an annual report.
- 9.4 The ICB must give a copy of its annual report to NHS England by the date specified by NHS England in a direction and publish the report.

Internal Audit

- 9.5 The Chief Executive, as the Accountable Officer, is responsible for ensuring there is appropriate internal audit provision in the ICB. For operational purposes, this responsibility is delegated to the Chief Finance Officer to ensure that:
- All internal audit services provided under arrangements proposed by the Chief Finance Officer are approved the Board of the ICB.
 - The ICB has an internal audit charter. The internal audit charter must be prepared in accordance with the Public Sector Internal Audit Standards (PSIAS).

- The ICB internal audit charter and annual audit plan, have been endorsed by the ICB Accountable Officer, Audit and Risk Assurance Committee and Board.
- The Head of Internal Audit provides an annual opinion on the overall adequacy and effectiveness of the 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 attends Audit and Risk Assurance Committee meetings and has a right of access to all audit and risk assurance Committee members, the Chair and Chief Executive of the ICB.
- The appropriate and effective financial control arrangements are in place for the ICB and that accepted internal and external audit recommendations are actioned in a timely manner.

External Audit

9.6 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 the ICB appoints an auditor in accordance with the Local Audit and Accountability Act 2014; in particular, the ICB must appoint a local auditor to audit its accounts for a financial year not later than 31 December in the preceding financial year; the ICB must appoint a local auditor at least once every 5 years (ICBs will be informed of the transitional arrangements at a later date); and,
- Ensuring that the appropriate and effective financial control arrangements are in place for the ICB and that accepted external audit recommendations are actioned in a timely manner.

10.0 Losses and special payments

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

10.2 The Chief 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.

10.3 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.

- 10.4 ICBs will work with NHS England teams to ensure there is assurance over all exit packages which may include special severance payments. ICBs have no delegated authority for special severance payments and will refer to the guidance on that to obtain the approval of such payments.
- 10.5 All losses and special payments (including special severance payments) must be reported to the Audit and Risk Assurance Committee.
- 10.6 For detailed operational guidance on losses and special payments, please refer to the ICB Losses and Special Payment Policy, which includes delegated limits.

11.0 Fraud, bribery and corruption (Economic crime)

- 11.1 The ICB is committed to identifying, investigating and preventing economic crime.
- 11.2 The 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 and Risk Assurance Committee, and defined roles and accountabilities for those involved as part of the process of providing assurance to the Board.
- 11.3 These arrangements should comply with the NHS requirements set out in [Government Functional Standard 013 Counter Fraud](#) as issued by NHS Counter Fraud Authority and any guidance issued by NHS England.

12.0 Capital Investments and security of assets and Grants

- 12.1 The Chief Finance Officer is responsible for:
- Ensuring that at the commencement of each financial year, the ICB and its partner NHS trusts and NHS foundation trusts prepare a plan setting out their planned capital resource use.
 - Ensuring that the ICB and its partner NHS trusts and NHS foundation trusts exercise their functions with a view to ensuring that, in respect of each financial year local capital resource use does not exceed the limit specified in a direction by NHS England.
 - Ensuring the ICB has a documented property transfer scheme for the transfer of property, rights or liabilities from the ICB's predecessor Clinical Commissioning Group.
 - Ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans.

- Ensuring that there are processes in place for the management of all stages of capital schemes, that will ensure that schemes are delivered on time and to cost.
 - Ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences; and,
 - Ensuring there are processes in place to ensure that a business case is produced for every capital expenditure proposal.
- 12.2 Capital commitments typically cover land, buildings, equipment, capital grants to third parties and IT, including:
- Authority to spend capital or make a capital grant, and,
 - Authority to enter into leasing arrangements.
- 12.3 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.
- 12.4 For operational purposes, the ICB shall have nominated senior officers accountable for ICB property assets and for managing property.
- 12.5 ICBs shall have a defined and established property governance and management framework, which should:
- Ensure the ICB asset portfolio supports its business objectives; and,
 - Comply with NHS England policies and directives and with this standard.
- 12.6 Disposals of surplus assets should be made in accordance with published guidance and should be supported by a business case which should contain an appraisal of the options and benefits of the disposal in the context of the wider public sector and to secure value for money.

Grants

- 12.7 The Chief Finance Officer is responsible for providing robust management, governance and assurance to the ICB with regards to the use of specific powers under which it can make capital or revenue grants available to:
- Any of its partner NHS trusts or NHS foundation trusts; and,
 - To a voluntary organisation, by way of a grant or loan.
- 12.8 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.

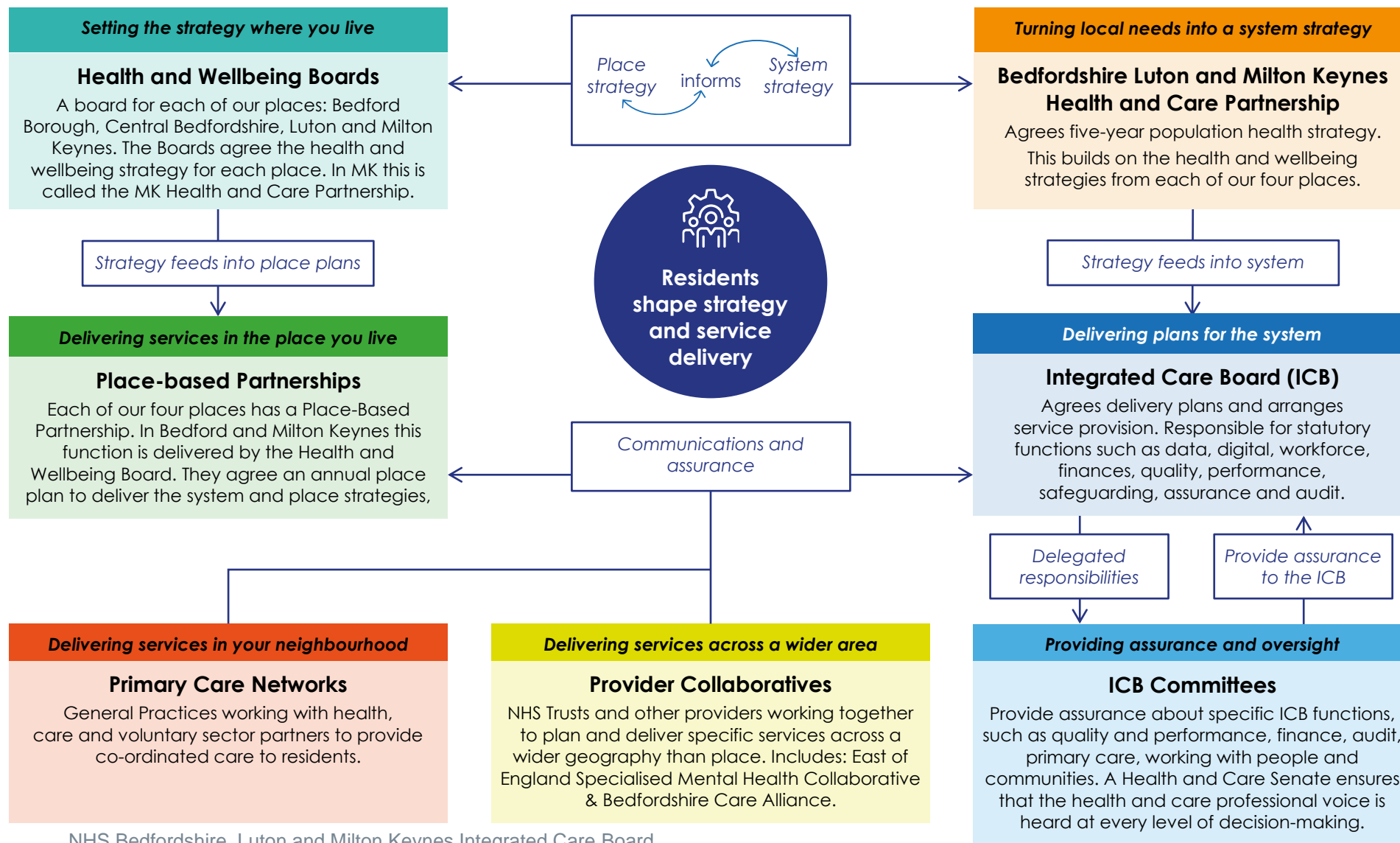
13.0 Legal and insurance

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

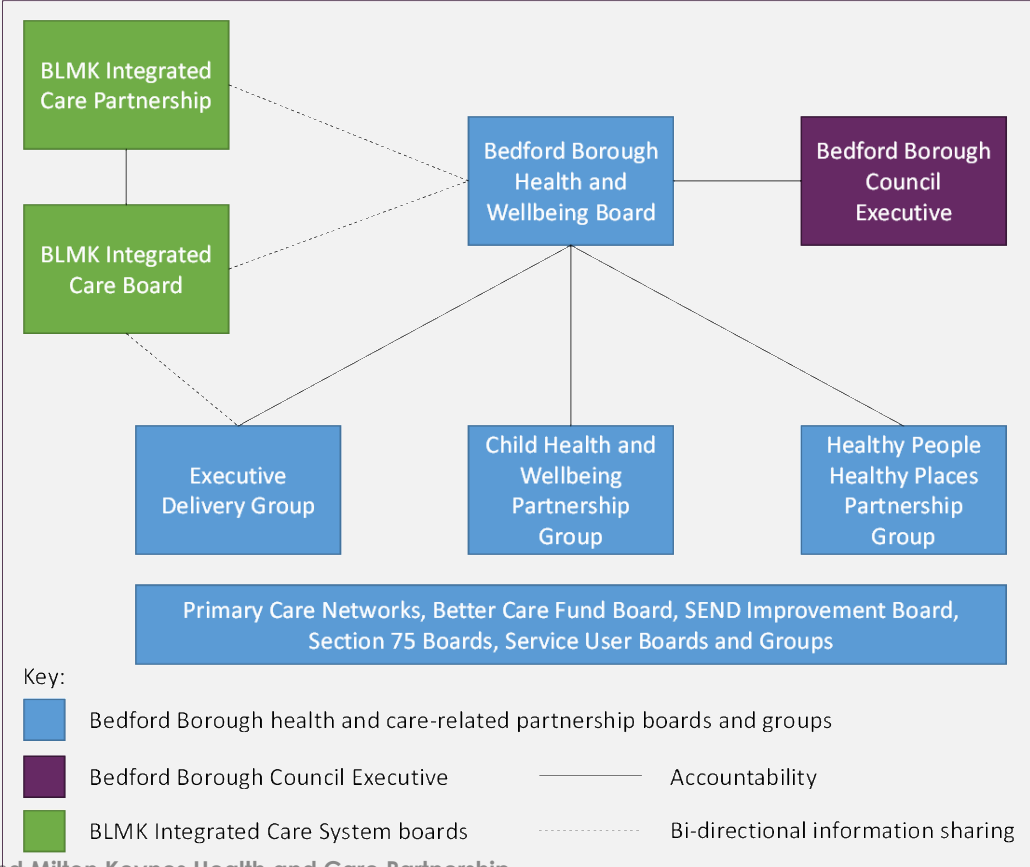
- Engagement of solicitors / legal advisors.
- Approval and signing of documents which will be necessary in legal proceedings; and,
- Officers who can commit or spend ICB revenue resources in relation to settling legal matters.

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

Appendix S – Bedfordshire, Luton and Milton Keynes Health and Care Partnership: How the system works (functions & decisions map) from 1 July 2022



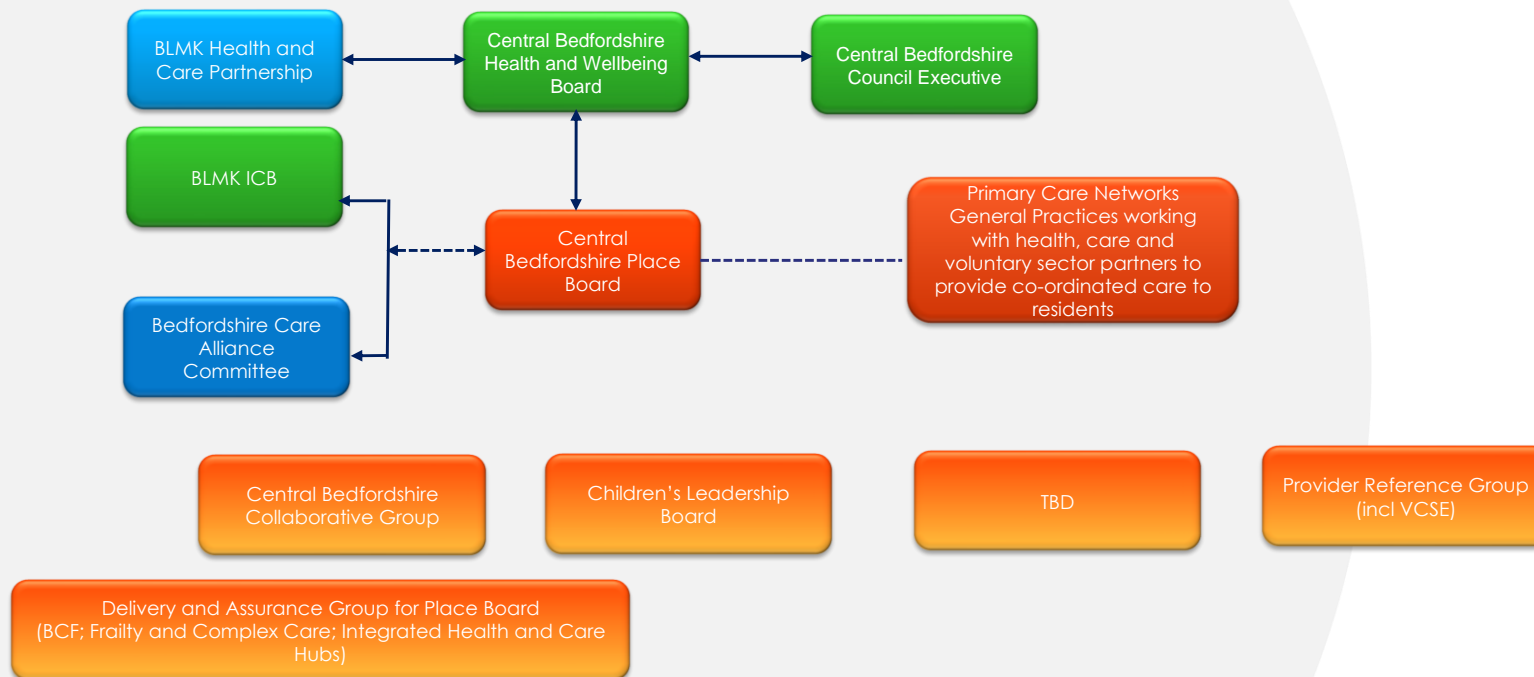
Place-Based Partnership arrangements for Health and Wellbeing in Bedford Borough



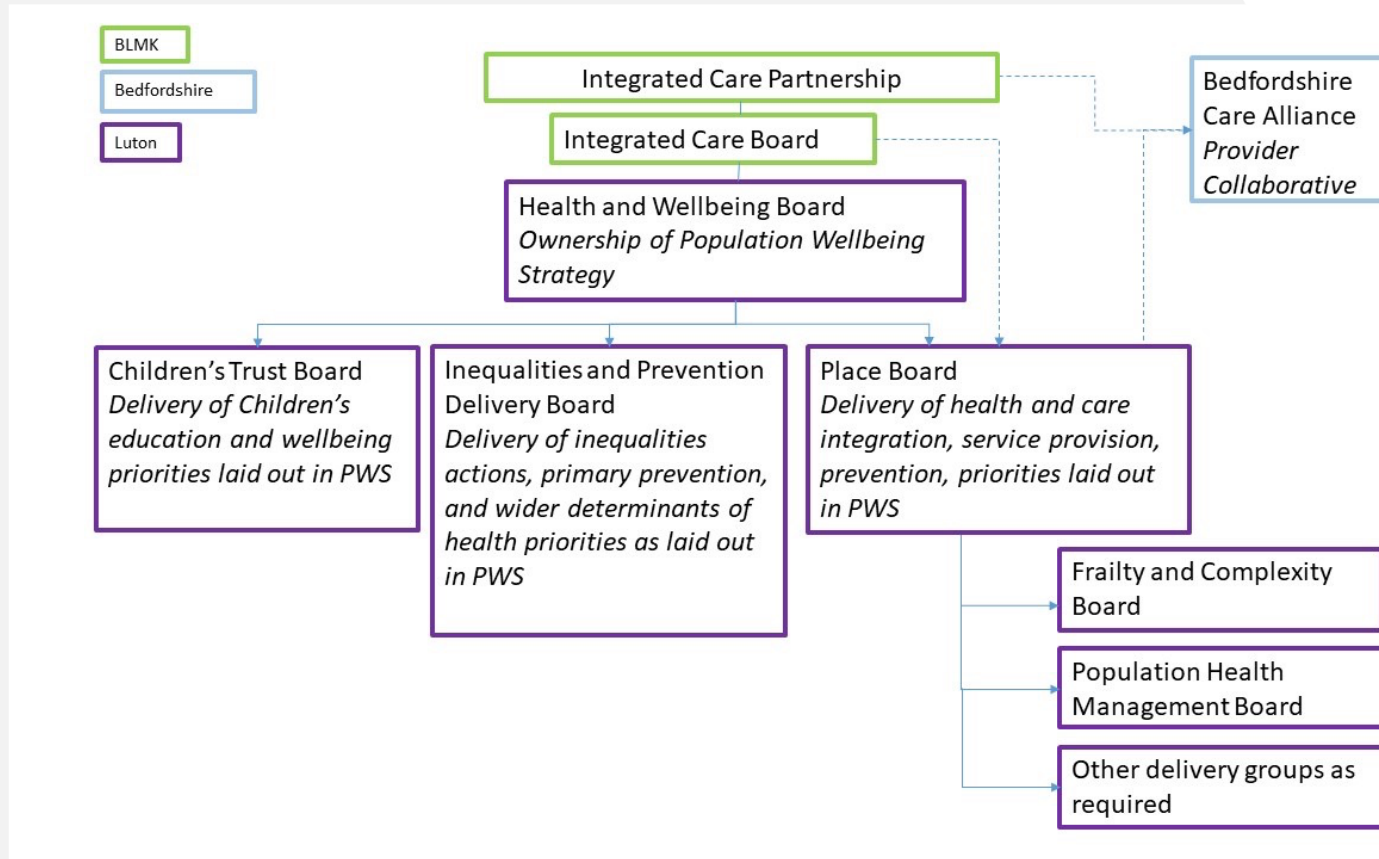
Bedfordshire, Luton and Milton Keynes Health and Care Partnership



Working draft - Place Based Partnership for Central Bedfordshire



Place-Based Partnership arrangements in Luton – Luton at Place Governance



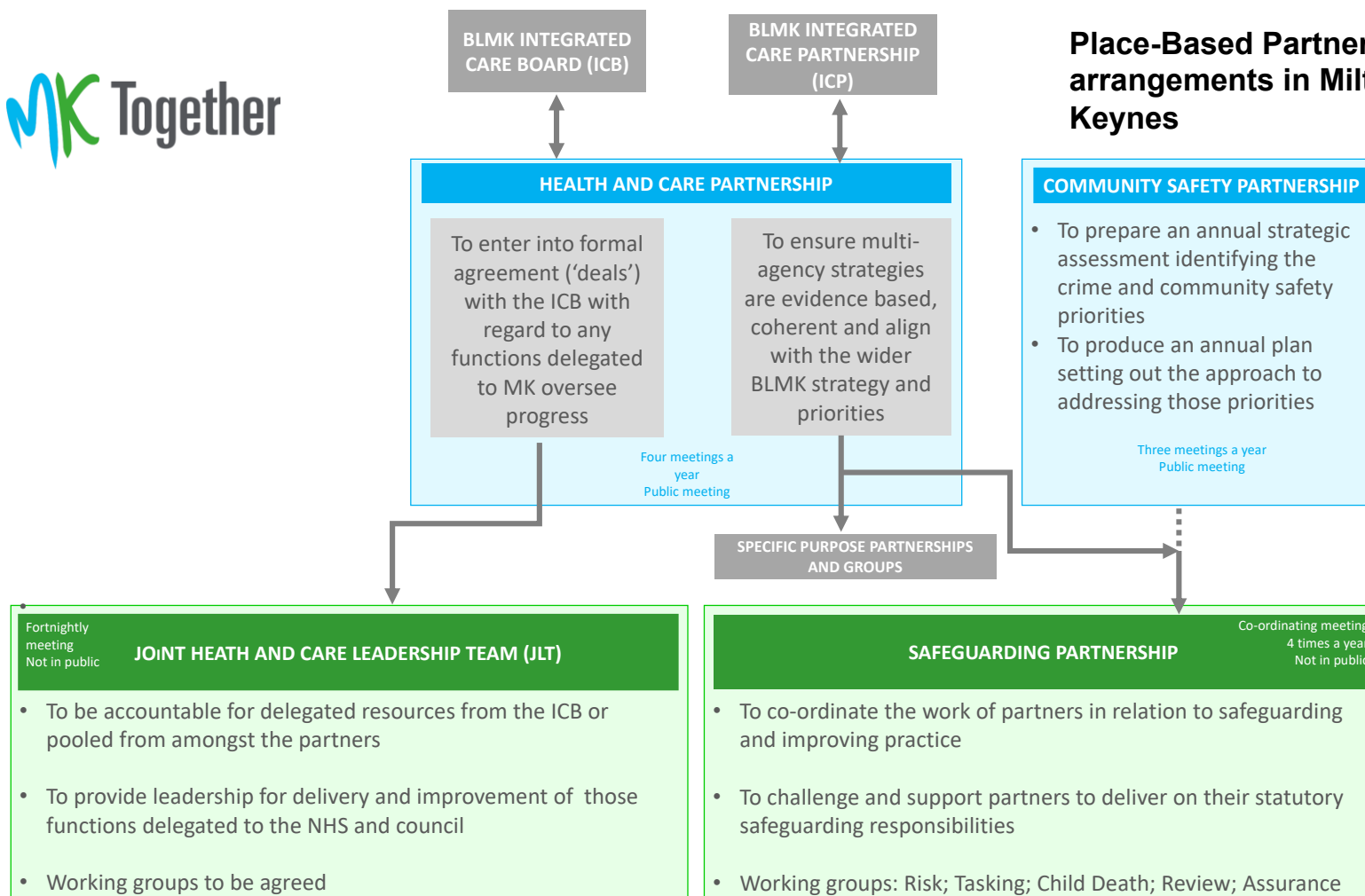
Bedfordshire, Luton and Milton Keynes Health and Care Partnership



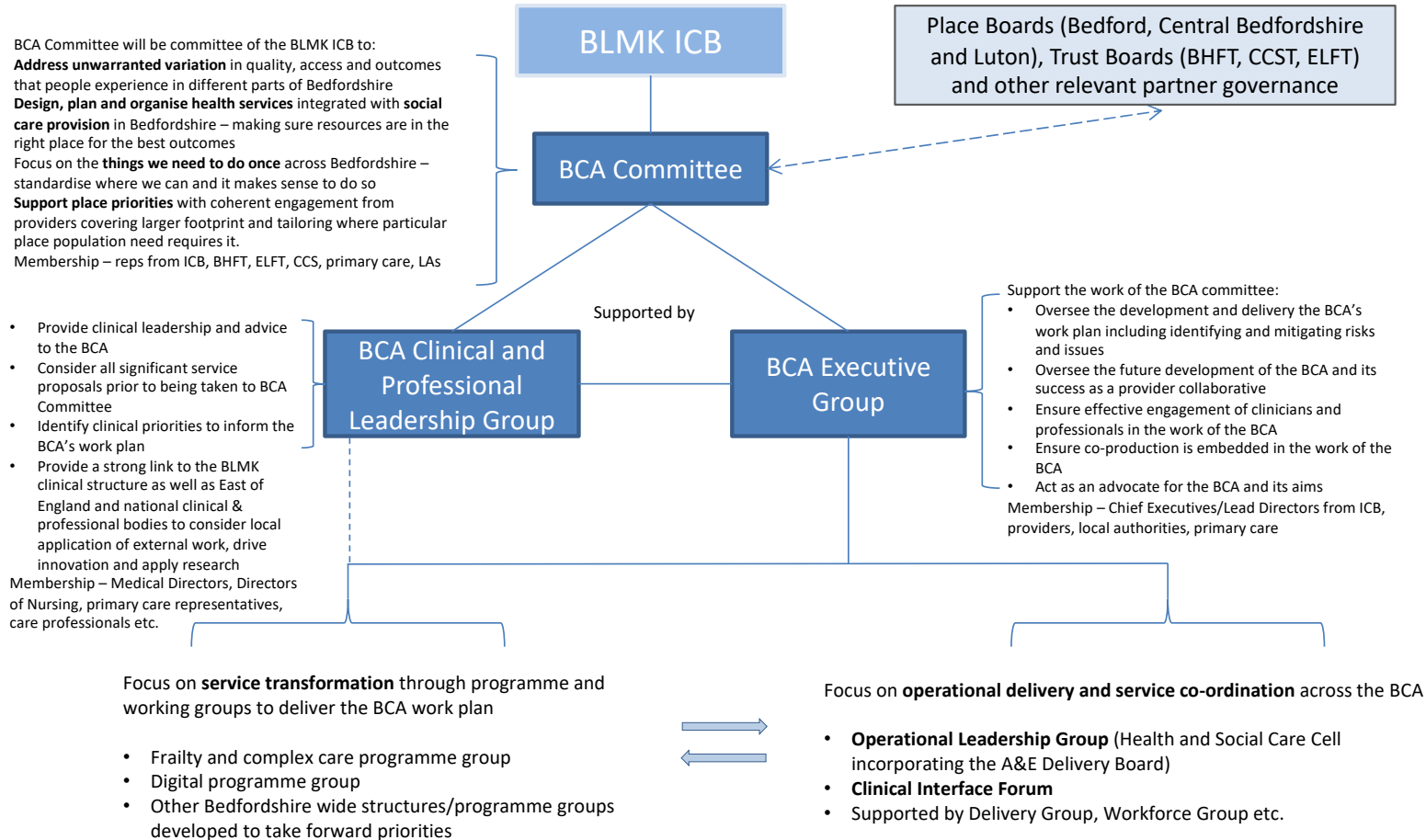
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Place-Based Partnership arrangements in Milton Keynes



Phase 1 BCA Governance Arrangements¹ (to be established in shadow from June 2022 and as Committee of the ICB from July 2022²)



Notes:

1. BCA Committee and BCA Clinical and Professional Leadership Groups are new to the structure in 2022
2. In line with new national timetable