NHS Devon Integrated Care Board Extraordinary Meeting in Public

Venue: Board Room, Aperture House, Pynes Hill, Exeter, EX2 5AZ
Date: 28 May 2026
Time: 10:00 – 10:25

Agenda

The quorum for meetings of the Board is at least 50% of its members:

a) Chair or Deputy Chair
b) At least two Executive Members
c) At least two Non-Executive Members
d) At least two of either the Partner Members or the Mental Health Member

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1.		Introductory Items	Lead	Action	Time
1.1	NHSD26-001	Welcome, introduction and apologies for absence	John Govett, Chair	Discussion	10:00
1.2	NHSD26-002	Declarations of interest	John Govett, Chair	Information	10:01
2.		**For Approval**	**Lead**	**Action**	**Time**
2.1	NHSD26-003	2025/26 Cluster Corporate Governance Framework Review	Philippa Harding, Company Secretary	Approval	10:02
3.		**Closing Items**	**Lead**	**Action**	**Time**
3.1	NHSD26-004	Any Other Business	John Govett, Chair	Discussion	10:25
		CLOSE			**10:30**

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Members

Name	Role	Organisation
John Govett	Chair	NHS Cornwall and Isles of Scilly and NHS Devon Cluster
Mark Hackett	Chief Executive (interim)	NHS Cornwall and Isles of Scilly and NHS Devon Cluster
Anne-Marie Bond	NHS Devon: Partner Member – Local Authorities	Chief Executive Officer, Torbay Council
Susan Bracefield	Chief Clinical Officer (Chief Nursing Officer)	NHS Cornwall and Isles of Scilly and NHS Devon Cluster
Graham Clarke	Non-Executive Member	NHS Cornwall and Isles of Scilly and NHS Devon Cluster
Peter Collins	Chief Population Health Officer	NHS Cornwall and Isles of Scilly and NHS Devon Cluster
Simon Gittoes-Davies	Chief Finance Officer	NHS Cornwall and Isles of Scilly and NHS Devon Cluster
Sam Higginson	NHS Devon: Partner Member - NHS Trusts and Foundation Trusts	Chief Executive Officer, Royal Devon University Healthcare NHS Foundation Trust
Tarn Lamb	Non-Executive Member	NHS Cornwall and Isles of Scilly and NHS Devon Cluster
Phill Mantay	NHS Devon: Mental Health Member	Chief Executive Officer, Devon Partnership NHS Trust
Dr Frank O'Kelly	NHS Devon: Partner Member – Providers of Primary Care Medical Services	GP Partner, Amicus Health
Lopa Patel	Non-Executive Member	NHS Cornwall and Isles of Scilly and NHS Devon Cluster
Chris Reid	Chief Place and Transformation Officer (Chief Medical Officer)	NHS Cornwall and Isles of Scilly and NHS Devon Cluster
Libby Ryan-Davies	Chief Strategic Planning and Commissioning Officer	NHS Cornwall and Isles of Scilly and NHS Devon Cluster
Martin Sykes	Non-Executive Member	NHS Cornwall and Isles of Scilly and NHS Devon Cluster
Neil Walden	Non-Executive Member	NHS Cornwall and Isles of Scilly and NHS Devon Cluster
Patrick Weir	Chief People Officer	NHS Cornwall and Isles of Scilly
Robert Williams	Non-Executive Member	NHS Cornwall and Isles of Scilly and NHS Devon Cluster

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Participants

Name	Role	Organisation
Diana Crump	NHS Devon: Voluntary Community and Social Enterprise (VCSE) Sector representative	Chair, Torbay, Plymouth and Devon VCSE Assembly
Philippa Harding	Company Secretary	NHS Cornwall and Isles of Scilly and NHS Devon Cluster
Dr Peter Roberts	NHS Devon: GP Collaborative Board Chair	GP Partner, Redfern Health Centre
Dr Lincoln Sargeant	NHS Devon: Director of Public Health	Director of Public Health, Torbay Council

Observers

Name	Role	Organisation
Rachel Pearce	Managing Director, NHS England South West Regional Team	NHS England

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NHS Devon Board Register of Interest - 28 May 2026

Employee	Role	Interest Type	Date Ended / Active	Interest Description	Interest Category	Mitigating Actions
John Govett	NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chair	Declaration of Interest	Ended 02/04/2026	I Co- Chair the ICP and sit on the CIOS Health & Wellbeing Board and also sit on the Cornwall Leadership Board.	Non-Financial Professional	Exclude myself from the meeting at that point where appropriate.
		Nil Declaration	Active	N/A	N/A	N/A
Anne-Marie Bond	NHS Devon: Partner Member - Local Authorities	Declaration of Interest	Active	Employment by Torbay Council as Chief Executive.	Non-Financial Professional	Awareness of role.
				Appointment as Chief Executive of the CCA.	Non-Financial Professional	Awareness by all of the position held.
Susan Bracefield	Chief Clinical Officer (Chief Nursing Officer)	Nil Declaration	Active	N/A	N/A	N/A
Helen Braid	Governance & Assurance Manager and Board Secretary	Nil Declaration	Active	N/A	N/A	N/A
Graham Clarke	Non-Executive Member	Declaration of Interest	Active	Non-Executive Director of Medicine Discovery Catapult.	Financial	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.
				Non Execuitve Member at the Deparment of Health & Social Care.	Financial	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.
				Trustee and Treasurer of the Cornwall Community Foundation.	Non-Financial Professional	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.
				Spouse is CEO of Cornwall Partnership Foundation Trust.	Indirect	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.

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NHS Devon Board Register of Interest - 28 May 2026

Employee	Role	Interest Type	Date Ended / Active	Interest Description	Interest Category	Mitigating Actions
Graham Clarke (Cont'd)	Non-Executive Member	Declaration of Interest	Active	Spouse is a Board Member of Cornwall & Isles of Scilly ICB.	Indirect	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.
				Member, Institute of Cancer Research.	Non-Financial Professional	To be managed in line with the Standards of Business Conduct Policy.
				Trustee of Picker Institute, a charity that advises on the design and policy for patient engagement and workforce satisfaction analysis.	Non-Financial Professional	To be managed in line with the Conflict of Interest Policy and Corporate Governance advice.
Peter Collins	Chief Population Health Officer	Declaration of Interest	Active	Trustee for Orchestras Live (charity promoting widening participation and community engagement within the orchestral sector).	Non-Financial Personal	To be managed in line with the Conflicts of Interest Policy.
				Spouse is Head of Clinical (Rehabilitation and Community) for NHS Supply Chain provides quality assurance for supply chain clinical products.	Indirect	Declare interest and recuse from any direct procurement decision making in relevant areas.
Diana Crump Braid Helen 21/05/2026 16:58:40	NHS Devon: Voluntary, Community and Social Enterprise (VCSE) Representative	Declaration of Interest	Active	I am a freelance VCSE mentor and consultant -Crump Consultancy through which I am commissioned by Devon Communities Together (DCT) under an MOU and funded through NHS Devon to provide 3.5 days of work as the Independent Chair of The TPD VSCE Assembly. I also undertake other freelance, self employed work to support charities and social enterprises to grow their organisations through mentoring, facilitation and other forms of support.	Financial	I will declare all conflicts in relation to any specific work that has any conflict with any topic areas discussed or on agendas to be discussed. I will ensure that all interactions in relation to this board are always strictly in relation to my role as a champion for the VCSE sector. To use integrity to ensure that I put aside any allegiances to particular organsations to champion all VCSE organisations across Devon.
Simon Gittoes-Davies	Chief Finance Officer	Declaration of Interest	Active	Company Director - Harrison Stickle Properties Ltd (dormant company).	Financial	To be managed in line with the conflict of interest policy and governance advice.

NHS Devon Board Register of Interest - 28 May 2026

Employee	Role	Interest Type	Date Ended / Active	Interest Description	Interest Category	Mitigating Actions
Mark Hackett	Interim Cluster Chief Executive Officer and Accountable Officer	Declaration of Interest	Ended 01/04/2026	Wife is the chair (unremunerated) of Sandwell Leisure Trust in the black country.	Indirect	To be managed in line with the Conflict of Interest Policy and Company Secretary advice.
			Active	Honorary Professor Swansea University.	Non-Financial Professional	To be managed in line with the Standards of Business Conduct and Conflict of Interest Policies.
				Wife is a Non-Executive Director at The Robert Jones and Agnus Hunt Orthopaedic Hospital.	Indirect	To be managed in line with the Standards of Business Conduct and Conflict of Interest Policies.
				Non-executive director Birmingham , black country and Solihull ICB.	Financial	To be managed in line with the Conflict of Interest Policy and Company Secretary advice.
Philippa Harding	Company Secretary	Declaration of Interest	Ended 01/04/2026	Interim Company Secretary for Cornwall and Isles of Scilly ICB as a secondary contract.	Financial	Will provide impartial, independent advice and guidance on areas relating to governance for both Devon and Cornwall ICBs, ensuring professional integrity at all times when working closely with the Chairs of both organisations in line with UKCGI Code of Professional Ethics and Conduct as well as each organisations Standards of Business Conduct and Conflict of Interest Policies.
			Active	Founding Director of Harding Advisory Ltd, a professional services company providing corporate governance expertise.	Financial	The company is currently dormant. Should any conflicts relating to NHS Devon be identified they will be managed as they arise in line with the NHS Devon Standards of Business Conduct Policy.
Sam Higginson	NHS Devon: NHS Trust and Foundation Trusts Partner Member	Declaration of Interest	Active	Chair of Enfield Unity Primary Care Network.	Non-Financial Professional	To be managed in line with the Standards of Business Conduct and Conflicts of Interest Policies.
				Committee Member - General Charity of the Royal Devon University Healthcare NHS Foundation Trust.	Non-Financial Professional	To be managed in line with the Standards of Business Conduct and Conflicts of Interest Policies.
				Chief Executive Officer Royal Devon University Healthcare NHS Foundation Trust.	Financial	To be managed in line with the Standards of Business Conduct and Conflicts of Interest Policies.

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NHS Devon Board Register of Interest - 28 May 2026

Employee	Role	Interest Type	Date Ended / Active	Interest Description	Interest Category	Mitigating Actions
Tarn Lamb	Non Executive Member	Declaration of Interest	Active	CEO at Cornwall Neighbourhood for Change Ltd.	Financial	CN4C is one of the partners for WorkWell. This is mitigated as follows:- There is a separate management group to oversee the programme- This individual has no responsibility for management of the ICB relationship with CN4C or budget/contracting decisions on CN4C funding. - CN4C's level of funding, along with its delivery and performance on WorkWell, managed through lead contractor, as part of its contracting arrangements with partner organisations. - This individual has no role in decision-making regarding which organisations the ICB will partner with on WorkWell.- The ICB Workforce committee would not be involved in operational decisions on WorkWell- Active, ongoing consideration during committee/Board meetings as to whether to step away from discussions which could impact CN4C as well as ICB.
				Director of start up CIC - employment and skills services company that will provide support to people who have previously been homeless.	Non-Financial Personal	Exclude from conflict situations should they arise.
				Director of High Heathercombe CIC a permaculture and residential centre.	Financial	To be managed in line with the Conflicts of Interest Policy and advice from the Governance Team.
Phillip Mantay	NHS Devon: Mental Health Member	Declaration of Interest	Active	Employed as Chief Executive Officer of Devon Partnership Trust since June 2024.	Financial	Declaration of relationship prior to offering opinion or recommendation.
				Children and Family Health Devon delivered services for Devon Partnership NHS Trust of which I am Chief Executive Officer.	Financial	To be managed in line with the conflict of interest policy and guidance from Corporate governance.

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NHS Devon Board Register of Interest - 28 May 2026

Employee	Role	Interest Type	Date Ended / Active	Interest Description	Interest Category	Mitigating Actions
Francis O'Kelly	NHS Devon: Partner Member - Providers of Primary Medical Services	Declaration of Interest	Ended 16/04/2026	GP Partner at Amicus Health Group. As well as providing the full range of Primary Care Services the practice is also a provider of Surgical Services (dermatology, carpal tunnel, vasectomies and minor ops) and Dermatology Services. Part of the merged practice is also dispensing.	Financial	Will be managed in line with the Standards of Business Conduct Policy and advice from governance.
			Ended 16/04/2026	My GP practice (Amicus Health) merged with the Mid Devon Medical Practice on 1.10.24 - Dr. Alex Degan (Medical Director for Primary Care at NHS Devon) is a partner in Mid Devon Medical Practice.	Indirect	I have declared the business of Amicus Health Group and will declare it at the start of any meeting where a conflict arises.
			Active	Blundell's School Lead Doctor.	Financial	Will be managed in line with the Standards of Business Conduct Policy and advice from governance.
				Member of the National Armed Forces Reference Group.	Non-Financial Professional	Will be managed in line with the Standards of Business Conduct Policy and advice from governance.
				Attends Tiverton High School Welfare Meeting fortnightly.	Non-Financial Professional	Will be managed in line with the Standards of Business Conduct Policy and advice from governance.
				Contributor to FASD Forum.	Non-Financial Professional	Will be managed in line with the Standards of Business Conduct Policy and advice from governance.
				5 adopted children, 2 with recognised learning difficulties both receiving PIP. One in supported living, the other recently moved (April 2026) to supported placement with Continuing Healthcare under DOLS.	Non-Financial Personal	Will be managed in line with the Standards of Business Conduct Policy and advice from governance.
				Wife is a book-keeper for STEER Eduction.	Financial	Will be managed in line with the Standards of Business Conduct Policy and advice from governance.

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NHS Devon Board Register of Interest - 28 May 2026

Employee	Role	Interest Type	Date Ended / Active	Interest Description	Interest Category	Mitigating Actions
Francis O'Kelly (Cont'd)	NHS Devon: Partner Member - Providers of Primary Medical Services	Declaration of Interest	Active	I attend a monthly online meeting of Primary Care Partner Members, which is organised and Chaired by the NHS Confederation.	Non-Financial Professional	Will be declare on Conflict of Interests at meetings.
				Member of the SW People Board.	Non-Financial Professional	To be managed in line with the conflicts of interest policy.
				GP Partner at Amicus Health. As well as providing the full range of Primary Care Services the practice is also a provider of Surgical Services (dermatology, carpal tunnel, vasectomies and minor ops) and Dermatology Services. Amicus Health employs General Practitioners with a Special Interest (GPSI) in both dermatology and surgery. We have GP registrars who are doing specialist modules in the practice in both these specialties. We merged with Mid Devon Medical Practice on 1.10.2024, so we are now based on 5 sites and dispense from three of them. Dr. Alex Degan (Medical Director for Primary Care at NHS Devon) is one of my Partners.	Non-Financial Professional	To be managed in line with the Conflict of Interest Policy and guidance from the Governance Team.
				The Partnership has set up a Limited Company with the intention of buying and running Bampton Pharmacy, which is presently renting space from the Partnership Estates.	Financial	Will be declared at all meetings where there is a potential COI.
Lopa Patel	Non-Executive Member	Declaration of Interest	Active	My daughter is undertaking a research-based PhD funded by AstraZeneca PLC, a supplier to the healthcare sector.	Indirect	Will seek advice from the Chair / step out of the room if there are commissioning decisions related to AstraZeneca PLC.

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NHS Devon Board Register of Interest - 28 May 2026

Employee	Role	Interest Type	Date Ended / Active	Interest Description	Interest Category	Mitigating Actions
Lopa Patel (Cont'd)	Non-Executive Member	Declaration of Interest	Active	Currently there are 12 members of my family, including my sister, nephews and nieces who work as doctors, dentists and pharmacists in the NHS, although none currently in the NHS Devon ICB commissioning region.	Indirect	Will seek the advice from the Chair and declare any direct interests if they arise.
				Currently Chair of equality charity, Diversity UK which is focusing on addressing inequalities, particularly for women and ethnic minorities. As a charity, Diversity UK, may receive donations from companies, organisation or individuals to help it deliver its mission. Donations are declared as per Charity Commission guidelines.	Financial	Will seek the advice from the Chair and declare any direct interests if they arise.
				Chair of the Finance & Performance Committee (F&PC); Member of RemCom & Member of NomCom at The National Archives (TNA), a non-ministerial department and the official archive and publisher for the UK Government.	Non-Financial Professional	Discussion & Review with the Chair of the Board.
				Board Member, Enterprising Women Programme at Murray Edwards College, University of Cambridge. The programme is sponsored by a number of companies, philanthropists and private donors including AstraZeneca UK, C Hoare & Co Private Bank, Innovate UK and others. The purpose of the programme is to create spin-outs from the University of Cambridge created by female postgraduates, researchers and staff. The programme currently does not accept under-graduates but this may change in the future.	Non-Financial Professional	I will excuse myself from any discussions related to the NHS or NHS Devon.

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NHS Devon Board Register of Interest - 28 May 2026

Employee	Role	Interest Type	Date Ended / Active	Interest Description	Interest Category	Mitigating Actions
Lopa Patel (Cont'd)	Non-Executive Member	Declaration of Interest	Active	I have been a judge for the The King's Awards for Enterprise Innovation Panel since 27 November 2017. This work is carried out with The King's Awards Office, part of the Department for Business & Trade (DBT) under a confidentiality agreement with recommendations from the innovation panel being put forward to the Prime Minister's Advisory Committee. However, I have recently been asked to promote the awards on social media with text and video clips. I have also previously been asked by DSIT/DBT & the Lord Lieutenancy to take part in online and in-person events to promote the awards.	Non-Financial Professional	Although I do not foresee any conflict of interest, there may be business applicants from the Devon area for whom I may have to declare an interest at panel (if they are a supplier to NHS Devon ICB) to ensure impartiality at the judging stage.
				KPMG sponsored Diversity UK, the charity that I chair, between 2015 and 2019. I have also worked with KPMG in my previous ARC role at the IPO.	Non-Financial Professional	Advice will be sought from the Chair of the Board & Senior Independent Director in the event of a conflict of interest.
Rachel Pearce	Managing Director, NHS England, South and West Regional Team	Declaration of Interest	Active	Trustee on the Marie Curie Board.	Non-Financial Personal	Withdrawal from meeting.
Chris Reid	Chief Place and Transformation Officer (Chief Medical Officer)	Declaration of Interest	Ended 01/04/2026	GP at UTC West Cornwall Hospital RCHT.	Financial	To be managed in line with the conflict of interest policy and governance advice.
			Active	Director of Horneywink Ltd - Orchard.	Non-Financial Personal	To be managed in line with the conflict of interest policy and governance advice.
				Board member - Health Innovation Network SW.	Financial	To be managed in line with the Conflict of Interest Policy and Corporate Governance guidance.
Peter Roberts	NHS Devon: GP Collaborative Board Chair	Declaration of Interest	Active	Chair of Devon Collaborative Board (DCB).	Non-Financial Professional	To be managed in line with the conflicts of interest policy.
				Chair of The Southern Primary Care Collaborative Board.	Non-Financial Professional	To be managed in line with the conflicts of interest policy.
				GP Partner The Redfern Health Centre.	Financial	To be managed in line with the conflict of interest policy.

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Employee	Role	Interest Type	Date Ended / Active	Interest Description	Interest Category	Mitigating Actions
Libby Ryan-Davies	Chief Strategic Planning and Commissioning Officer	Declaration of Interest	Active	I am currently working on establishing a personal consultancy business.	Financial	Potential future work will not be undertaken in the South West of England.
Lincoln Sargeant	NHS Devon: Director of Public Health, Torbay Council	Nil Declaration	Active	N/A	N/A	N/A
Martin Sykes	Non-Executive Member	Declaration of Interest	Active	NED University Hospitals Bristol and Weston NHS Foundation Trust and member of their ICB Finance, Estates and Digital Committee.	Financial	Awareness and removal from potential conflict situations should they arise.
				Daughter is on the NHSE Graduate Scheme and has been placed at RDUH in a Junior Trainee Role.	Indirect	To be managed in line with the Conflict of Interest Policy and advice from the Governance Team.
Neil Walden	Non Executive Member	Declaration of Interest	Active	Member of Penwith Integrated Care Forum - public facing group.	Non-Financial Professional	To be managed in line with the Conflict of Interest Policy and Corporate Governance advice.
Patrick Weir	Chief People Officer	Nil Declaration	Active	N/A	N/A	N/A
Robert Williams	Non-Executive Member	Declaration of Interest	Active	Trustee with Devon Community Foundation – newly appointed to the Board.	Non-Financial Personal	To be managed in line with the Conflicts of Interest Policy and Corporate Governance advice.

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NHS Devon Integrated Care Board Meeting in public

2025/26 Cluster Corporate Governance Framework Review

Date of meeting	Date report produced
28 May 2026	08 May 2026

Author(s)		Report approved by	
Name and title:	K Kingan, Interim Head of Corporate Governance	**Name and title:**	Philippa Harding, Company Secretary

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
N/A

Executive summary
To strengthen the governance of the NHS Cornwall and Isles of Scilly (CIOS) and NHS Devon Integrated Care Board (ICB) Cluster arrangements, an advisory review of governance committees and frameworks was commissioned at the end of the 2025/26 financial year (the 2025/26 Cluster Corporate Governance Framework Review). This report presents findings from the first of what is proposed will be an annual assessment, with a view to promiting good governance and continuous improvement. A summary of common themes and committee-wide actions identified in the 2025/26 Cluster Corporate Governance Framework Review Report was considered in detail at the meeting of the NHS CIOS and NHS Devon Audit and Risk Committees in common on 20 April 2026. In addition to consideration of the outcomes at the meeting of the South West Peninsula Board in private on 30 April 2026, each of its committees have also had the opportunity to review the feedback and the proposed actions to address areas for improvement, where applicable, to be taken forward in 2026/27. General findings can be summarised as:

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- Committee Terms of Reference (ToR), such as the responsibilities of both the Finance, Quality & Performance Committees (FQPCs), were high-level and lacked detail on what is required to meet those responsibilities.
- Overlap between SWP Neighbourhood Health Improvement Committee (NHIC) and SWP People, Customer Experience and Equity Committee (PCEEC) ToR, with both seeking assurance about the "improvement of health outcomes and the reduction of health inequalities".
- As the ToR for the two FPQCs is quite high-level, it was difficult to confirm full discharging of responsibilities via the agenda items.
- Work plans still in development for the SWP NHIC and SWP PCEEC at the time of the review, making it difficult to assess whether areas of responsibility in the ToR had been achieved.

This report proposes amendments to the core elements of the NHS CIOS and NHS Devon ICB Cluster Corporate Governance Framework in response to the findings of the 2025/26 Cluster Corporate Governance Framework Review.

Committees that have previously discussed/agreed the report, and outcomes of that discussion

- **Audit and Risk Committees** meeting in common – 20 April 2026, endorsed the proposed response to the Cluster Corporate Governance Framework Review
- **Remuneration Committees** meeting in common – 28 April 2026 endorsed the proposed response to the Cluster Corporate Governance Framework Review with regard to the issues specific to that Committee
- **South West Peninsula Board** meeting in private – 30 April 2026, endorsed the proposed response to the Cluster Corporate Governance Framework Review
- **South West Peninsula Planning Committee, Cornwall and Isles of Scilly Finance, Performance and Quality Committee, Devon Finance, Performance and Quality Committee, South West Peninsula People, Customer Experience and Equity Committee** and **South West Peninsula Neighbourhood Health Improvement Committee** all considered the proposed response to the Cluster Corporate Governance Framework Review with regard to the issues to specific to each Committee in correspondence during April 2026
- **South West Peninsula Management Board** - 13 May 2026 agreed to recommend the this report to the NHS Cornwall and Isles of Scilly and NHS Devon Integrated Care Boards

Key recommendations and actions requested

TAKE SATISFACTORY ASSURANCE from the process of the advisory review on the effectiveness of the corporate governance framework underpinning the operation of the NHS Cornwall and Isles of Scilly and NHS Devon Integrated Care Board Cluster arrangement (the 2025/26 Cluster Corporate Governance Framework Review).

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TAKE SATISFACTORY ASSURANCE that the proposed amendments to the core elements of the NHS Cornwall and Isles of Scilly and NHS Devon Integrated Care Board Cluster Corporate Governance Framework respond appropriately to the findings of the advisory review on the effectiveness of the governance framework underpinning the operation of the NHS Cornwall and Isles of Scilly and NHS Devon Integrated Care Board Cluster arrangement.
AGREE the proposed changes to the following Corporate Governance Framework documents: • Joint Standing Financial Instructions • Joint Operational Scheme of Delegation • Governance Handbook • Joint Policy on the Development & Management of Procedural Documents • Joint Policy on Standards of Business Conduct • Joint Policy for the Management of Conflicts of Interest • Joint Policy on Risk Management • Joint Policy on the Receipt, Acceptance and Management of Petitions • Audit and Risk Committee Terms of Reference • Remuneration Committee Terms of Reference • South West Peninsula Board (SWPB) Terms of Reference • South West Peninsula Management Board (SWPMB) Terms of Reference • Transition Steering Group (TSG) Terms of Reference • South West Peninsula Planning Committee Terms of Reference • Cornwall and Isles of Scilly Finance, Performance and Quality Committee Terms of Reference • Devon Finance, Performance and Quality (FPQ) Committee Terms of Reference • South West Peninsula Neighbourhood Health Improvement Committee (NHIC) Terms of Reference • South West Peninsula People, Customer Experience and Equity Committee (PCEEC) Terms of Reference • Board/Committee Report template

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	No specific issues arising from this report.
Health inequalities	
Workforce	

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Resources and finance	
Legal	
Digital and Data	
Involvement, Engagement and consultation	
Other – sustainability etc	

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2025/26 Cluster Corporate Governance Framework Review

Introduction and background

1. Following approval from NHS England (NHSE) for the Cluster arrangement between NHS Cornwall and Isles of Scilly (CIOS) and NHS Devon Integrated Care Boards (ICBs), in August 2025 the Boards of each ICB agreed the establishment of a Joint Committee (known as the South West Peninsula Board (SWPB)) and arrangements for the governance and oversight of the Cluster until the point of formal merger, which is currently anticipated April 2027.

2. The SWPB went on to establish a number of Committees to support the delivery of its responsibilities. The Committees' roles include reviewing the comprehensiveness, reliability, and integrity of assurances, each within a remit outlined in an approved Terms of Reference (ToR).

3. The ToR for the Committees established by the SWPM align with the NHS Devon and NHS CIOS Joint Scheme of Reservation and Delegation (SoRD) and Standing Financial Instructions (SFIs), and form part of the broader Cluster Corporate Governance Framework.

4. The Committees of the SWPB are:

    - Transition Steering Group
    - South West Peninsula Planning Committee
    - Cornwall and Isles of Scilly Finance, Performance and Quality Committee
    - Devon Finance, Performance and Quality (FPQ) Committee
    - South West Peninsula Neighbourhood Health Improvement Committee (NHIC)
    - SWP People, Customer Experience and Equity Committee (PCEEC)

5. NHS CIOS and NHS Devon retained the following separate ICB Committees, which meet in common under the Cluster arrangement:

    - Audit and Risk Committee
    - Remuneration Committee

6. An internal review of the effectiveness of existing Committees should be carried out at least annually. This is in line with good governance practice and a cycle of continuous improvement.

7. The internal auditors of NHS CIOS (TiAA) and NHS Devon (ASW) jointly undertook the 2025/26 advisory review in late January and early March 2026. This report summarises the process, findings, and proposed actions to be taken in response.

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2025/26 Cluster Corporate Governance Framework Review - process and findings

Process

8. The approach for the 2025/26 Cluster Corporate Governance Review was approved by the Audit and Risk Committees meeting in common on 01 December 2025.

9. In addition to a review of the documentation supporting the Corporate Governance Framework, the effectiveness of the Committees was assessed through the following:

    A. Interviews with the SWPB Chair and Committee Chairs and a sample of Chief Officers.
    B. An online survey of SWPB Non-Executive Members (NEMs) was conducted.
    C. A review of Committee meeting minutes and agendas to assess their coverage against the ToRs and work programme. An assessment of attendance and contributions was also made.

10. Internal Audit colleagues reviewed the results to identify common themes, which are summarised below.

General Observations

11. Committee ToR, such as the responsibilities of both the Finance, Quality & Performance Committees (FQPCs), were high-level and lacked detail on what is required to meet those responsibilities.

12. Overlap between SWP NHIC and SWP PCEEC ToR, with both seeking assurance about the "*improvement of health outcomes and the reduction of health inequalities*".

13. As the ToR for the two FPQCs were quite high-level, it was difficult to confirm full discharging of responsibilities via the agenda items.

14. Work plans were still in development for the SWP NHIC and SWP PCEEC at the time of the review, making it difficult to assess whether areas of responsibility in the ToR had been achieved.

15. Membership and meeting quorum are established through each Committee's ToR, approved by the SWPB as the suitable combination of skills and expertise aligned with the Committee's specific remit and responsibilities. Overall, the Review found evidence that members' attendance at meetings in 2025/26 was satisfactory across all Committees, with quorums consistently met.

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16. Monitoring of the Board Assurance Framework (BAF) should sit with the Audit and Risk Committees, with all other Committees responsible for overseeing their allocated strategic / BAF risks.

17. Greater use of real-time/live data dashboards for use across Board and Committee reporting was recommended.

18. There was interviewee recognition of the different needs of the two ICBs – NHS CIOS' need to progress and NHS Devon's to improve, with sharing learning where suitable. This should be reflected in meeting agendas, timings, etc.

Interview and Survey Feedback

19. Internal Audit interviewed a selection of NEMs to gain insight into their views on the effectiveness and operation of the new NHS CIOS and NHS Devon ICB Cluster Corporate Governance Framework, including the SWPB.

20. Some of the key observations noted are set out below:

- Currently, there is still some overlap of reporting/discussions throughout the governance structure (e.g. PCEEC and FPQ). Some papers are going to multiple Committees.
- Papers were felt to be improving, but still too long, and appendices were difficult to read (small spreadsheets).
- Lack of use of data dashboards. Need more information on outcomes to explore root cause and potential solutions, then.
- Lack of provider presentation/representation and meetings in Devon compared to previous Cornwall practices. Lack of urgency/traction for change as a result. Allocated BAF risks should be set out upfront in committee agendas to set the focus. However, this can only be achieved once the strategic objectives are set and the associated BAF risks are updated. BAF is currently too lengthy.
- The executives do not always write board papers; therefore, the exec summaries are not necessarily what the Board needs (too detailed).

Responding to the 2025/26 Cluster Corporate Governance Framework Review – proposed changes for 2026/27

21. Alongside the work undertaken by internal audit colleagues, the Corporate Governance team has been considering potential amendments to the documentation underpinning the governance framework for the NHS CIOS and NHS Devon ICB Cluster, in order to ensure that it is effective as possible. Based on the practical experience of supporting the Corporate Governance framework, this has included key changes needed to reflect updates to the executive leadership team, routine annual revisions, and feedback and observations from the 2025/26 Cluster Corporate Governance Framework Review.

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22. The documents reviewed to that the Cluster Corporate Governance Framework remains current, fit for purpose, and aligned with national expectations include:

- Constitution and Standing Orders
- Joint Scheme of Reservation and Delegation
- Joint Standing Financial Instructions
- Joint Operational Scheme of Delegation
- Governance Handbook
- Joint Policy on the Development & Management of Procedural Documents
- Joint Policy on Standards of Business Conduct
- Joint Policy for the Management of Conflicts of Interest
- Joint Policy on Risk Management
- Joint Policy on the Receipt, Acceptance and Management of Petitions

23. The 2025/26 Cluster Corporate Governance Framework Review provides an opportunity to harmonise the suite of documents set out above, taking the best aspects from each ICB and reducing inconsistencies in approach across the ICB, such as:

- Use of version control.
- Different approaches as to whether provinces are reviewed annually or every three years.
- Although documents are comprehensive, they are too ‘wordy’ and may impact staff's ability to comprehend and apply.
- Reconciliation of cross-references between governance documents and committee terms of reference (e.g. petitions policy states reporting of the log of petitions to the Audit and Risk Committee (ARC); however, this is not in the ARC ToR).
- Equality, Diversity and Inclusion (EDI) statements are not always used consistently across the polices.

24. Revised documents are all appended to this report, for approval. Where no revisions are proposed, these documents are not appended to this report but can be found elsewhere on the website.

Constitution, including Standing Orders

25. All ICBs are required to adopt and publish a Constitution that outlines how they will function and make decisions concisely and transparently. The NHS Devon and NHS CIOS Constitutions follow the Model Constitution issued by NHS England NHSE in 2024, with minimal local content added where permitted, as previously approved by the respective Boards and NHSE.

26. In light of the fact that the NHS CIOS and NHS Devon Constitutions were reviewed in September 2025 and will be reviewed again in advance of an anticipated merger of the two ICBs in April 2027, they were not included within the scope of this work; however, comments made by internal audit colleagues will be taken account of when this work is undertaken.

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Standing Financial Instructions (SFIs)

27. SFIs define the purpose, responsibilities, legal framework, and operating environment of the ICB. They enable sound administration, reduce the risk of irregularities, and support the commissioning and delivery of effective, efficient, and economical services. The following changes are proposed following the review:

- Establishment of Joint SFIs for NHS CIOS and NHS Devon
- Responsibility for the Internal Audit service now sits with the Company Secretary rather than the Chief Finance Officer.
- The inclusion of Digital/ Cyber Security in both SFI's.

Scheme of Reservation and Delegation (SoRD)

28. All ICB Boards need a SoRD, which sets out the functions reserved to the ICB Board and those delegated by the ICB, which must be agreed in accordance with (and be consistent with) the Constitution. In light of the fact that the Joint SoRD was agreed by both Boards in August 2025 and based on this review, no changes are proposed to the SoRD.

Corporate Governance Handbook

29. The NHS Devon and NHS CIOS Constitutions mandate a Handbook that summarises the ICB's governance arrangements, including links to the ToR, a governance diagram, and key partnership information. The Governance Handbook has been refreshed with the following proposed changes:

- Harmonise both Governance Handbooks where possible, introducing a single presentation format and version control.
- Updated executive roles and responsibilities to reflect recent organisational change
- Updated the committees to reflect the cluster arrangements and membership
- Two new slides relating to risk management and the BAF.

Corporate Governance Policies

30. NHSE requires that all ICBs have a Standards of Business Conduct (SoBC) policy and a Conflicts of Interest (COI) policy. Additionally, the Cluster Corporate Governance Framework identifies the following further core corporate governance policies, requiring Board review and approval:

- Joint Policy on the Development & Management of Procedural Documents
- Joint Policy on Standards of Business Conduct
- Joint Policy for the Management of Conflicts of Interest
- Joint Policy on Risk Management
- Joint Policy on the Receipt, Acceptance and Management of Petitions

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31. Policy templates have been reviewed to ensure compliance with accessible information standards, and equality and diversity statements have been added to the instructions for all policies. Policies have been aligned so that they are now proposed to be joint policies shared by both NHS CIOS and NHS Devon ICBs.

Board/Committee Effectiveness

32. The ToR of each Board Committee have been reviewed and a number of amendments made in response to the findings of the 2025/26 Cluster Corporate Governance Framework Review. However, it is not proposed to amend the ToRs of the Committees significantly at the current time, as there is a hypothesis that any lack of clarity between them will be addressed through the development of detailed workplans by Chief Officers. Where there were specific comments relating to overlap between Committee ToRs (i.e. PCEEC and NHIC) these have been addressed.

33. The Chair, NEMS and Company Secretary met on 14 May 2026 to discuss how to continually improve Committee effectiveness. It was agreed that the FPQ Committees should continue to focus on in-year delivery (including in terms of workforce) with the PCEEC and NHIC focussing more on longer term and population health issues. The detail of this would be worked out through the workplans of each Committee.

34. It is anticipated that the identification of detailed workplans will provide clarity with regard to the required meeting cadence for each Committee (potentially resulting in fewer meetings than currently). These workplans will align to the Business Plan for the NHS CIOS and NHS Devon ICB Cluster that is currently being developed and is due to be presented to the SWPB for approval in June/July 2026.

35. The finalisation of the Board Assurance Framework will also enable strategic risks to be allocated to each Committee and so each Committee will be able to focus on seeking assurance in respect of these.

36. Outside the feedback from Internal Audit colleagues, NEMs and Chief Officers, a representation has been received from Devon County Council with regard to the membership of the SWPB, specifically the request has been made to have dedicated representation of Devon County Council on the SWPB. This representation was discussed in detail at the meeting of the SWPB in public on 26 March 2026, at which it was agreed that this was not required; therefore no amendment to the SWPB membership is proposed at this time.

37. Now that Cluster Chief Officers have been appointed and an Interim Chief Executive Officer has been appointed, a formal structure for Executive decision-making is required. It is proposed that a Management Board is established as a sub-group of the SWPB, chaired by the Interim Chief Executive Officer, with all Chief Officers as members, attended by the Company Secretary and supported by the organisation's Secretariat.

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38. Chief Officers are responsible for commissioning and approving any reports that are due to be submitted to a Committee or Board. They are also responsible for ensuring that reports are provided in a timely manner, and that any changes to agreed Committee or Board agendas are agreed with the Chair of that meeting.

39. It is proposed that, throughout 2026/27 Chief Officers should work to develop the manner in which information is provided to each Committee and the Board. This should move towards a greater focus on quantitative information (rather than narrative) with analysis and identified actions to achieve specific outcomes. Where possible dashboard reporting should be provided, including Statistical Process Control (SPC) data. Where narrative reports are required, report authors should be provided with coaching/mentoring to support their understanding of what is required.

40. Stakeholders participating in the 2025/26 Cluster Corporate Governance Framework Review acknowledged that, whilst Board and Committee papers were improving, concerns remain about their length and the presentation of data. The template for the Board and Committees was reviewed to support consistent, concise reporting and to provide guidance for paper authors.

Recommendations

41. The NHS Cornwall and Isles of Scilly Integrated Care Board is asked to:

- **TAKE SATISFACTORY ASSURANCE** from the process of the advisory review on the effectiveness of the corporate governance framework underpinning the operation of the NHS Cornwall and Isles of Scilly and NHS Devon Integrated Care Board Cluster arrangement (the 2025/26 Cluster Corporate Governance Framework Review).
- **TAKE SATISFACTORY ASSURANCE** that the proposed amendments to the core elements of the NHS Cornwall and Isles of Scilly and NHS Devon Integrated Care Board Cluster Corporate Governance Framework respond appropriately to the findings of the advisory review on the effectiveness of the governance framework underpinning the operation of the NHS Cornwall and Isles of Scilly and NHS Devon Integrated Care Board Cluster arrangement.
- **AGREE** the proposed changes to the following Corporate Governance Framework documents:
  - Joint Standing Financial Instructions
  - Joint Operational Scheme of Delegation
  - Governance Handbook
  - Joint Policy on the Development & Management of Procedural Documents
  - Joint Policy on Standards of Business Conduct
  - Joint Policy for the Management of Conflicts of Interest
  - Joint Policy on Risk Management
  - Joint Policy on the Receipt, Acceptance and Management of Petitions
  - Audit and Risk Committee Terms of Reference

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- Remuneration Committee Terms of Reference
- South West Peninsula Board (SWPB) Terms of Reference
- South West Peninsula Management Board (SWPMB) Terms of Reference
- Transition Steering Group (TSG) Terms of Reference
- South West Peninsula Planning Committee Terms of Reference
- Cornwall and Isles of Scilly Finance, Performance and Quality Committee Terms of Reference
- Devon Finance, Performance and Quality (FPQ) Committee Terms of Reference
- South West Peninsula Neighbourhood Health Improvement Committee (NHIC) Terms of Reference
- South West Peninsula People, Customer Experience and Equity Committee (PCEEC) Terms of Reference
- Board/Committee Report template

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NHS Devon
NHS Cornwall and Isles of Scilly
Joint Standing Financial Instructions

Document Reference	Joint Standing Financial Instructions
Version	V1
Senior Responsible Officer	Company Secretary
Author/s	Head of Corporate Governance
Approved by	NHS Devon Integrated Care Board NHS Cornwall and Isles of Scilly Integrated Care Board
Date Approved	28 May 2026
Date Issued	1 June 2026
Date of next review	31/03/2027

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1. Introduction

1.1. These joint standing financial instructions (SFIs) do not form part of either NHS Devon or NHS Cornwall and Isles of Scilly Integrated Care Board's (ICB) Constitution but are required to be published. Together with the delegated financial limits, they are incorporated into the governance handbook of each ICB in accordance with 1.7.3(d) of their Constitutions.

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 its duties.

1.3. The purpose of this governance document is to ensure that both ICBs fulfil their statutory duty to conduct their functions effectively, efficiently, and economically. The SFIs are part of the ICBs' 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 ICBs. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient, and economical services.

1.5. The ICBs are established under Chapter A3 of Part 2 of the National Health Service Act 2006, as inserted by the Health and Care Act 2022, and have 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 each ICB (its board) and all other officers should be aware of the existence of these documents and be familiar with their detailed provisions. The ICBs' SFIs will be made available to all officers on the intranet and internet website for each statutory body.

1.8. Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the Chief Executive Officer or the Chief 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.

1.10. All members of each ICB Board and other officers have a duty to disclose any non-compliance with these SFIs to the Chief Executive Officer or Chief Finance Officer, who shall escalate the matter where appropriate.

1.11. The Chief Finance Officer shall ensure that the SFIs are reviewed at least annually. The SFIs, and any amendments to them, shall be approved by each ICB Board.

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2. Scope

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

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

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

2.4. Unless a contrary intention is evident, or the context requires otherwise, words or expressions contained in this document will have the same meaning as set out in the applicable Act.

3. Roles and Responsibilities

Staff

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. Each ICB Constitution provides for the ICB Chair to appoint the Chief Executive Officer. The Chief Executive Officer is the accountable officer for each 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 Officer will delegate to the Chief Finance Officer the following responsibilities in relation to the ICB:

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- preparation and audit of annual accounts;
- adherence to the directions from NHS England in relation to accounts preparation;
- ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly with system partners;
- ensuring that there is an effective financial control framework in place to support

accurate financial reporting, safeguard assets and minimise risk of financial loss;

- meeting statutory requirements relating to taxation;
- ensuring that there are suitable financial systems in place
- meeting the financial targets set by NHS England;
- use of incidental powers such as management of ICB assets, entering commercial agreements;
- ensuring the Governance statement and annual accounts & reports are signed;
- ensuring planned budgets are approved by the relevant Board; developing the funding strategy for the ICB to support the board in achieving ICB objectives, including consideration of place-based budgets;
- making use of benchmarking to make sure that funds are deployed as effectively as possible;
- executive members (partner members and non-executive members) and other officers are notified of and understand their responsibilities within the SFIs;
- specific responsibilities and delegation of authority to specific job titles are confirmed;
- financial leadership and financial performance of the ICB;
- identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions; and
- the Chief Finance Officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risk.

Audit and Risk Committee

3.5. The board and accountable officer should be supported by an Audit and Risk 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. 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.

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

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

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

4.5. The Chief Finance Officer supported by other ICB Directors shall promote a culture where budget holders and decision makers consult their finance business partners in key strategic decisions that carry a financial impact.

5. Income, banking arrangements and debt recovery

Income

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

5.2. 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 existing Shared Services provider; and
- ensuring the debt management strategy reflects the debt management objectives of the ICBs and the prevailing risks;

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Banking

5.3. The Chief Finance Officer is responsible for ensuring the ICBs comply 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 ICBs hold the minimum number of bank accounts required to run the organisation effectively. These should be raised through the government banking services contract; and
- the ICBs have 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 ICB board every 12 months to ensure relevance and provide assurance;
- accountability to the ICB board that debt is being managed effectively;
- accountabilities and responsibilities are defined with regards to debt management to budget holders; and
- responsibility to appoint a senior officer responsible for day to day management of debt.

6. Financial systems and processes

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.

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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 ICBs meet the required financial and governance reporting requirements as a statutory body by the effective use of finance systems;
- enable the prevention and the detection of inaccuracies and fraud, and the reconstitution of any lost records;
- ensure that the financial transactions of the authority are recorded as soon as, and as accurately as, reasonably practicable;
- ensure publication and implementation of all ICB business rules and ensure that the internal finance team is appropriately resourced to deliver all statutory functions of the ICBs;
- 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 ICBs;
- ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes; and
- where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

7. Procurement and purchasing

Principles

7.1. The Chief Finance Officer will take a lead role on behalf of the ICBs 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 ICBs 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 ICBs must consider, as appropriate, any applicable NHS England guidance that does not conflict with the above.

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7.4. The ICBs 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 ICBs' 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 ICBs' Joint Policy on Standards of Business Conduct.

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 PCR 2015 and the ICBs' procurement policy.

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

8. 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 ICBs ensuring this reflects and integrates the strategies of all relevant partner organisations within each ICS.

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.
- The Chief People Officer will ensure that the payroll system has adequate internal controls and suitable arrangements for processing deductions and exceptional payments.
- Where a third-party payroll provider is engaged, the Chief People Officer shall closely manage this supplier through effective contract management.

8.3. The Chief People Officer is responsible for management and governance frameworks that support the ICB employees' life cycle.

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9. Annual reporting and Accounts

9.1. The Chief Finance Officer will ensure, on behalf of the Accountable Officer and ICB boards, that:

- the ICBs can produce their required monthly reporting, annual report, and accounts, as part of the setup of the new organisation; and
- the ICBs, in each financial year, prepare a report on how they have discharged their functions in the previous financial year;
- An annual report must, in particular, explain how the ICB has:
    - discharged its duties in relating to improving quality of services, reducing inequalities, the triple aim and public involvement;
    - review the extent to which the board has exercised its functions in accordance with its published 5 year forward plan and capital resource use plan; and
    - review any steps that the board has taken to implement any joint local health and wellbeing strategy.

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

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

Internal audit

9.4. The Chief Executive Officer, as the accountable officer, is responsible for ensuring there is appropriate internal audit provision in the ICBs. For operational purposes, this responsibility is delegated to the Company Secretary to ensure that:

- all internal audit services provided under arrangements proposed by the Chief Finance Officer are approved by the Audit and Risk Committees, on behalf of the ICB boards;
- the ICB must have an internal audit charter. The internal audit charter must be prepared in accordance with the Public Sector Internal Audit Standards (PSIAS);
- the ICB internal audit charter and annual audit plan, must be endorsed by the ICB Accountable Officer, Audit and Risk Committee and board;
- the head of internal audit must provide an annual opinion on the overall adequacy and effectiveness of the ICB Board's framework of governance, risk management and internal control as they operated during the year, based on a systematic review and evaluation;
- the head of internal audit should attend audit and risk assurance committee meetings and have a right of access to all audit and risk assurance committee members, the Chair and Chief Executive Officer 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.

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External Audit

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

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

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

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

11. Fraud, bribery and corruption (Economic crime)

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11.1. The ICBs are 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 Committee and defined roles and accountabilities for those involved as part of the process of providing assurance to the board.

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

12. Capital Investments & security of assets and Grants

12.1. The Chief Finance Officer is responsible for:

- ensuring that at the commencement of each financial year, the ICBs and their partner NHS trusts and NHS foundation trusts prepare a plan setting out their planned capital resource use;
- ensuring that the ICBs and their 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 ICBs have a documented property transfer scheme for the transfer of property, rights or liabilities from ICBs' predecessor clinical commissioning group(s);
- ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- ensuring that there are processes in place for the management of all stages of capital schemes, that will ensure that schemes are delivered on time and to cost;
- ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences; and
- for every capital expenditure proposal, the Chief Finance Officer is responsible for ensuring there are processes in place to ensure that a business case is produced.
- Capital commitments typically cover land, buildings, equipment, capital grants to third parties and IT, including:

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

12.2. 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.

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

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

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

12.5. 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

12.6. 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.

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

13. Legal and insurance

13.1. This section applies to any legal cases threatened or instituted by or against the ICBs. The ICBs 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 ICB revenue resources in relation to settling legal matters.

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

14. Digital

14.1. The Chief Finance Officer is responsible for the accuracy and security of the ICBs' computerised financial data and shall:

- devise and implement any necessary procedures to ensure adequate (reasonable) protection of the ICBs' data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018.
- ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and

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timeliness of the data, as well as the efficient and effective operation of the system.
- ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment.
- ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews are conducted.

14.2. In addition, the Chief Finance Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested before implementation. Where another organisation undertakes this, assurances of adequacy must be obtained from them before implementation.

Accounting Systems

14.3. The Chief Finance Officer will ensure:

- The ICBs' suitable financial and other software to enable them to comply with these policies and any consolidation requirements of NHS England.
- 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.

14.4. 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.

Responsibilities and Duties of Other Directors and Officers in relation to Computer Systems of a General Application

14.5. In the case of computer systems which are proposed for General Applications (i.e. normally those applications which the majority of NHS Integrated Care Boards in the region wish to sponsor jointly), all responsible directors and employees will send to the Chief Finance Officer:

- details of the outline design of the system
- in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

15. Review

15.1. These SFIs will be revised annually to ensure it remains up-to-date and relevant. Following consultation with the Executive Directors and scrutiny by the ICB's Audit and Risk Committee, the Company Secretary will recommend amendments, as fitting, to the ICB Board for approval.

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NHS Devon

NHS Cornwall and Isles of Scilly

Joint Operational Scheme of Delegation

Document Reference	Joint Operational Scheme of Delegation
Version	V1
Senior Responsible Officer	Chief Finance Officer
Author	Company Secretary
Approved by	NHS Devon Integrated Care Board NHS Cornwall & Isles of Scilly Integrated Care Board
Date Approved	28 May 2026
Date Issued	01 June 2026
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Change Record

Date	Version	Status	Author	Changes Made
May 2026	V1	Draft	PH/KK	Creation of Joint OSoD

Review

This OSoD will be reviewed annually to ensure it reflects changes in legislation, ICB policy, ongoing operational requirements and national guidance.

The NHS Devon and NHS Cornwall and Isles of Scilly Integrated Care Boards will each approve this Document.

References

Authorised individuals need to familiarise themselves with essential guidance. This knowledge is key to ensuring compliance and enhancing overall effectiveness.

- Governance Handbook – Standing Financial Instructions
- HM Treasury: Managing Public Money (updated June 2025).
- NHSE - The Provider Selection Regime (PSR) statutory guidance (Updated April 2025).
- Health Care Services (Provider Selection Regime) Regulations 2023
- The Procurement Regulations 2024
- Procurement Act 2023
- Procurement of goods or services process (NHS Devon)

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Operational Scheme of Delegation (OSoD)

This schedule of matters delegated to NHS Devon and NHS Cornwall and Isles of Scilly (CIOS) officers (Operational Scheme of Delegation, or OSoD) has been developed in conjunction with the Standing Orders (SOs) and Standing Financial Instructions (SFIs) of NHS Devon and NHS CIOS. This document should be used in conjunction with the NHS Devon and NHS CIOS Joint Scheme of Reservation and Delegation (SoRD), the difference being that this document sets out the operational and financial limits on the authority delegated within NHS Devon and NHS CIOS.

The delegations articulated in this document are the lowest level to which authority is delegated. Authority can be delegated upwards with no further action being required. Decision making with a financial impact must be carried out in accordance with the NHS Devon and NHS CIOS SOs, SFIs and detailed financial procedures. All financial limits in this OSoD are subject to the availability of sufficient budget. The Limits set out in this OSoD are the maximum limits, and lower limits may be applied.

In accordance with SoRD, the NHS Devon and NHS CIOS Boards exercise financial supervision and control by:

a) Authorising the operational plan of each Integrated Care Board;

b) Requiring the submission and approval of budgets within approved allocations / overall income;

c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

d) Defining specific responsibilities placed on members of each Integrated Care Board, its Committees, partners and employees as indicated in the SoRD.

Once the NHS Devon and NHS CIOS Boards have reviewed and approved the Operating Plan and any supporting financial plan/budget, the Board will delegate approval to the Chief Executive, the Chief Finance Officer and other Chief Officers and employees to commit these resources for the purpose set out in the plan, subject to the financial thresholds set out in this OSoD.

N.B. Both NHS Devon and NHS CIOS operate with additional financial governance either by way of double or triple lock processes. The objective of these additional controls is to provide system wide scrutiny of any investments over a certain threshold (currently £100,000 TCV). There are no exceptions to this process and seeking approval through this process must be sought before any contracts/ procurement can be initiated.

In the event of long-term absence or sickness, requests for a change to the delegation must be made in writing and clearly describe the parameters of the delegations, including financial limits and any restrictions for types of expenditure, to the Chief Executive Officer and the Chief Finance Officer, on the advice of the Company Secretary.

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Individuals with delegated responsibility

Individuals who have delegated responsibility given to them in line with the scheme of delegation must have due regard to:

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

Individuals are also expected to ensure that they are familiar with the following guidance:

- NHS Cornwall and Isles of Scilly and NHS Devon Joint Standing Financial Instructions (SFIs)
- NHS Cornwall and Isles of Scilly and NHS Devon Joint Scheme of Reservation and Delegation (SoRD)
- HM Treasury: managing public money
- NHS Cornwall and Isles of Scilly and NHS Devon Joint Policy on Standards of Business Conduct
- NHS Cornwall and Isles of Scilly and NHS Devon Joint Policy on the Management of Conflicts of Interest
- Procurement of goods or services policies (relevant ICB until standardised)
- Budget holder manual (relevant ICB until standardised)

Current versions of the Joint Standing Financial Instructions (SFIs), Joint Scheme Of Reservation and Delegation (SoRD), and Joint Policy on Standards of Business Conduct can be found on the public facing website.

If an individual is unsure of their obligations or authority under this scheme of delegation, they should seek advice from appropriate senior officers before entering into any commitment, whether oral or written, or taking any other action that may put them in breach of these requirements.

If any individual becomes aware that they have acted in breach of this scheme of delegation, or believes they may have done so, they should immediately report this to the Chief Finance Officer and the Company Secretary regardless of the context and reasons.

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General Delegation Principles

Delegates Must

- Act within your authority by ensuring you hold the relevant delegation
- Understand your authority by referring to relevant guidance, limitations and directions
- Act with the ICB's values in mind
- Avoid conflicts of interest
- Consider the ICB's business needs
- Seek expert advice **before** making a decision
- Make decisions objectively, reasonably and fairly.

Delegates MUST NOT

- Exercise delegations in respect of someone outside of your immediate line of control
- Exercise powers in respect of a position higher than your own
- Exercise a delegation in respect of yourself (i.e. confer a personal benefit)
- Exercise a delegation on behalf of an absent employee unless it is within the scope of your delegated authority, or you are officially acting in the position.

Compliance:

- All delegates are required to comply with manuals and directives issued by the ICB
- Delegated authority is subject to internal controls and to any overriding National laws

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Finance Delegation Principles

Delegates MUST

- Only commit expenditure in cost centres under the delegate's authority
- Only commit expenditure where there is sufficient budget to cover the cost *
- Only commit expenditure on goods and services related to official work and business use
- Only commit expenditure where all relevant ICB's procedures and policies have been followed
- Only commit expenditure to the financial limit of the delegation
- Only approve expenditure where evidence exists that goods have been received and/or services have been performed in accordance with and at the rate/s of an agreed contract or arrangement

** In the event that additional commitments are considered necessary when a budget is already committed, specific approval to overspend will be required from the Chief Finance Officer, and is only likely to be given in exceptional circumstances*

Delegates MUST NOT

- Approve a gift or settlement of any legal claim unless specifically delegated this authority
- Transfer the financial delegation granted by the ICB Chief Executive to another employee
- Break one purchase down into several smaller items to avoid breaching the financial limit of the delegation
- Commit expenditure on capital works, contracts or special payments unless specifically delegated this authority
- Exceed their delegation limits even if automated systems permit this to occur
- Approve any expenditure incurred by the delegate on travel, meals, conferences and other similar expenditure
- Assume the financial delegation of an absent delegate if you are not authorised to do so.

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Individuals with delegated responsibility

Unless specified elsewhere in this Scheme of Delegation the following apply:

N.B. Individuals who are formally appointed in an "interim" or "acting" capacity to any of Tier 1 or Tier 2 roles shall have the same authority as substantive appointees.

Tier 1 (Chief Officers)
The following are defined as Tier 1:

NHS Devon	NHS CIOS
Chief Executive Officer/Accountable Officer	
Chief Finance Officer	
Chief Strategic Planning and Commissioning Officer	
Chief Clinical Officer (CNO)	
Chief Place and Transformation Officer (CMO)	
Chief People Officer	
Chief Population Health Officer	
Company Secretary	

Role	Nature of role	Accountable to
Budget manager	the team member with delegated authority for day-to-day budget management	Head of service
Director/Head of Service	Responsible for financial management of budget	Chief Officer
Chief Officer	Overall accountability for activities within their directorate	Chief Executive Officer
Chief Executive Officer	Overall accountability for the operations of the ICB	ICB Board

Tier 2 (directors/deputies)
The following are defined as Tier 2:

NHS Devon	NHS CIOS
Director of Finance (Operations)	
Director of Finance (Strategy and Planning)	
Director of Finance (Transformation)	
Director of Estates	
Director of Nursing & AHP (Quality)	
Director of Nursing & AHP (Statutory/Partnerships)	
Director of Nursing & AHP (Operations and Transformation)	
Director of Population Health Management & Prevention	
Director of Data Insights and Health Intelligence	
Director of Digital Development	
Director of Strategic Planning	
Director of Commissioning	
Director of Experience & Engagement	
Place Director	
Director of Primary Care	
Director of Service Transformation	
Medical Director (Regulation & Transformation)	
Director of Workforce Strategy, Planning and Change	

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Procurement of goods or services (1 of 2)

As a public body, the NHS is subject to public procurement legislation:

- The NHS Provider Selection Regime 2023 (the PSR) applies to all healthcare services.
- The Procurement Act 2023 applies to the procurement of goods and non-healthcare services
- The Public Contracts Regulations 2015 (PCR) remain applicable for certain legacy procurements and arrangements.

Before procuring goods and services delegates should read the relevant ICB's Procurement Policy

Contact Contracting/Procurement First

Always contact the Contracting team first before approaching any provider. This ensures the correct process, documentation, and compliance requirements are in place from the outset. Early engagement supports better planning, avoids delays, and ensures all activity follows approved procedures

Contacting Providers

Once advised by the Contracting team the provider contact should be **limited to obtaining quotations and lead times**. **No commitments** to procure or contract with the provider should be made.

A purchase can only proceed after:

A compliant route to market is confirmed
Internal governance approvals are completed
Formal intention to award is issued

Role of the Contracting team

The team will advise on the **most appropriate procurement route and manage the route to market.** This ensures the process is **legally compliant** and follows procurement regulations. It will also help you embed **financial and commercial governance** throughout. (Please note that the approval value of procurements under both PSR and PA will need to follow the approval route that equates to the whole life value of the procurement and not just the annual value.)

Importance of Planning Ahead

Procurement activities—tenders, approvals, and contract finalisation—**take time**. Early planning supports the timely delivery of projects and allows us to be compliant with our internal governance and providers better outcomes.

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Due consideration must be made to the separate guidance on Managing Public Money issued by HM Treasury. This stresses the importance of operating with regularity and propriety and the need for efficiency, economy, effectiveness, and prudence in the administration of public resources, to secure value for public money. Conflicts of Interest must be checked for staff and potential providers, as well as required mandatory checks (such as mandatory exclusions, financial standing).

Procurement of goods or services (2 of 2)

Healthcare Services	Health Adjacent Services, Goods, Non-Healthcare
Clinically led services **Consultant, GP, Nurse, Paramedic, Health Care Practitioner**	**All other goods and services**
Legislation - NHS PROVIDER SELECTION REGIME	**Legislation - PROCUREMENT ACT 2023**
Direct Award are first choice where: **A.** A single capable provider **B.** ICB are not restricting number of providers, and patient choice. **C.** Existing Provider satisfies existing need and is likely to do so going forward (not changing materially) - Urgent situations (with conditions) **Route C** – Must publish an Intention to Award before the service starts to allow other Providers to make representations, full contract award cannot be made until after 8 day standstill. Cannot it be used for new services. **Where Direct Awards are not permissible/suitable, we must use :** - Most Suitable Provider (publicised EOI process) - Competitive Process **No financial thresholds are applicable as <u>all spend</u> is subject to the rules.**	**The Act applies for contract values above the following thresholds:-** **Health Adjacent services: £663,540** **Corporate services, Goods IM&T: £135,018** **Below the thresholds** **Three Quotes or Direct Award (SATW)** **Above the thresholds** **Direct Awards (SATWs) are permissible, the following conditions apply:** - Pilot/test & learn only (cannot extend) - One single capable supplier (market assessment done) - Additional or repeat goods or services - Due to Insolvency - Extreme and unavoidable urgency - To protect life where Minister of the Crown considers it necessary (eg Covid). **Where Direct Award is not permissible/suitable, we must use:** - Competitive Process

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All options require publicised Transparency Notices including Direct Awards and must be published by Procurement Team on the national portal.
See FAQs for more information.
Do not have discussions with providers before seeking advice from the procurement team.

Delegation Limits (1 of 4)

Individuals can only apply delegation limits to budgets for which they are accountable. Whilst budget holders may delegate to people they line manage in accordance with the scheme of delegation; they cannot delegate accountability. Delegations are not cumulative (i.e. cannot be used by two officers together to achieve a higher delegation limit)

Nothing in this scheme of delegation is intended to preclude the pragmatic progress of legitimate ICB business. Where the Chief Executive Officer and/or Chief Finance Officer consider there are legitimate reasons to depart from the below delegations, they can do so with the Board's prior engagement and agreement.

Ref	Responsibility	Delegation Arrangements	Notes
1 - Business cases/Committing Expenditure			
1.1	**Approval of business cases –**		Costs incurred in the delivery of services to patients. These limits refer to approval of the business cases prior to the commencement of a direct award or a competitive procurement process. These must be read in conjunction with the ICS wider system governance for system financial governance setting out arrangements for all partner organisations Annualised value means twelve month's expenditure (eg a contract value for £1million covering a 4-year period has an annualised contract value of £250k) **All commitments should only be within delegated budgets**
	Programme expenditure (All limits relate to annualised expenditure)		
	Up to £250,000	Tier 2	
	£250,001 to £1,000,000	Tier 1	
	£1,000,001 up to £5,000,000	Chief Executive and Chief Finance Officer	
	Over £5,000,001 up to £20,000,000	South West Peninsula Management Board	
	Over £20,000,000	South West Peninsula Board	
1.2	**Approval of business cases –**		Running costs are costs incurred in the running of the ICB as an organisation **All commitments should only be within delegated budgets**
	Running costs (administrative costs) (All limits relate to annualised expenditure)		
	Up to £100,000 (within approved delegated budgets)	Tier 2	
	£100,001 up to £250,000	Tier 1	
	£250,001 to £500,000	Chief Executive and Chief Finance Officer	
	£500,001 to £2,000,000	South West Peninsula Management Board	
	Over £2,000,000	South West Peninsula Board	

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Delegation Limits (2 of 4)

Ref	Responsibility	Delegation Arrangements	Notes
2 – Contract approval			
2.1	**Authorisation to sign the legal contract**		(All limits relate to annualised expenditure) For individual packages of care see 2.2 **All approvals should only be within delegated budgets**
	Purchase of goods and services		
	Up to £250,000	Tier 2	
	£250,001 to £1,000,000	Tier 1	
	£1,000,001 up to £5,000,000	Chief Executive and Chief Finance Officer	
	Over £5,000,001 up to £20,000,000	South West Peninsula Management Board	
	Over £20,000,000	South West Peninsula Board	
2.2	**Purchase of individual packages of care**		Such purchases can only be authorised where there is an extant, relevant overarching contract in place with the specific Provider. If such a contract does not exist, compliant procurement routes must be followed. (All limits relate to annualised expenditure) **All approvals should only be within delegated budgets**
	Up to £1,000 per week	Band 6	
	Up to £1,900 per week	Band 7	
	Up to £2,200 per week	Band 8a	
	Up to £3,000 per week	Band 8D	
	Up to £4,800 per week	Band 9	
	Over £4,800 per week	In line with 2.1 above (on an annualised basis)	

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Delegation Limits (3 of 4)

Ref	Responsibility	Delegation Arrangements	Notes
2.3	**Temporary increases (maximum 4 weeks) to individual packages of care**		There may be occasions where a temporary increase is required to an existing package of care, such as when an individual is in crisis and requires one to one support. Delegating these approval limits, for a maximum of 4 weeks, will allow timely decisions to support individuals with existing packages. If the increase is expected to continue and will exceed 4 weeks then the approval needs in line with section 2.2 above
	Up to £500 per week	Band 8a	
	Up to £1,000 per week	Band 8b	
	Purchase of running costs/administrative cost goods and/or services		(All limits relate to annualised expenditure) **All approvals should only be within delegated budgets**
	Up to £100,000	Tier 2	
	£100,001 up to £250,000	Tier 1	
	£250,001 to £500,000	Chief Executive and Chief Finance Officer	
	£500,001 to £2,000,000	South West Peninsula Management Board	
	Over £2,000,000	South West Peninsula Board	
3 – Approval of invoices within ORACLE			
3.1	Up to £500	Band 4	Evidence of a contract/grant/formally approved should be in place before approval.
	Up to £15,000	Band 5-6	
	Up to £50,000	Band 7-8	
	Up to £20,000,000	Band 8d	
	Up to £30,000,000	Tier 2	
	£30,000,001 and over	Chief Executive or Chief Finance Officer	
3.2	Invoices relating to individual packages of care		Limits apply to individual invoices only when the package of care has been approved on the care system and invoices are matched to the relevant package of care. Approval of the invoice cannot be provided by the same person who approved the care package (or changes to the care package).
	Up to £10,000	Individual package of care finance administrator - Band 3 - 5	
	Up to £20,000	Individual package of care business manager, operational managers - Band 8A	
	Up to £100,000	Band 8d	
	Over £100,000	Tier 2	

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Delegation Limits (4 of 4)

Ref	Responsibility	Delegation Arrangements	Notes
4 – Use of corporate credit card			
4.1	Expenditure in relation to travel and accommodation where request has been approved in line with relevant limits above	Named Personal Assistants as approved by Chief Finance Officer (refer to Credit Card Policy)	The use of credit cards is mainly for travel and accommodation. Staff who need to book travel and accommodation for business use must obtain prior approval from their manager. Once prior approval has been gained, the team's personal assistant will then make the necessary travel arrangements in accordance with NHS CIOS Travel and Subsistence Expenses Policy and NHS Devon Travel Expenses.
	Use of credit cards for other expenditure	Up to £1000 Tier 2 Over £1000 Tier 2 - Director of Finance	
5 – Authorisation of Invoice Payment Files (IPF)			
5.1	Authority to approve IPF payments	Tier 2 - Director of Finance	Invoice payment files (IPFs) are mainly used for payment of • NHS providers within scope (as directed by NHSE) • Continuing Healthcare where the provider meets qualifying criteria (Control over CHC packages lies in the authorisation of the package of care within the care management software) • Personal Health Budget payments • GP payments on an adhoc basis In accordance with overarching contract This delegation relates to authorisation of the payment files to be uploaded
5.2	Continuing Healthcare/ Personal Health budgets	Band 8b	
	GP payments	Band 8b	
6 - Income			
6.1	All requests for a sales invoice will be on the prescribed form (with relevant back information/agreement attached) approved as follows:		The ICB receives most of its cash funding from the Department of Health however, there will be instances where sales invoices are raised. Where there are amounts owed to the ICB and an invoice is required to be raised the process should be initiated without undue delay as this could give rise to a credit risk. Credit notes requests will be agreed within the same limits as the sales invoices. Credit notes will be authorised within the finance system by the Head of Finance
	Up to £100,000	Band 7	
	Up to £1,000,000	Band 8d	
	Over £1,000,000	Tier 2	
	Sales Invoices will be raised by Finance staff and authorised within SBS by:		
	Up to £500,000	Band 8a	
	Over £500,000	Band 8d	
	Approval of external process to seek recovery of debts	Band 8d	

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Technical and/or financial system related matters (1 of 2)

Delegated Matters	Minimum authorisation level	Notes
Monthly cash requisitions		
Monthly drawdown funding request	Band 8a	The ICB is funded by monthly funding requests – these are submitted in the month prior funding being required.

General Ledger

Responsibility	Minimum authorisation level	Notes
Journals		
Up to £1,000,000	Band 5	Processing of all General Ledger Journals (Budget, Actuals and Accruals)
Up to £20,000,000	Band 8a	
Over £20,000,000	Band 8b	
Financial ledger code combinations		
Requests to create or disable code combinations.	Band 5	
Purchase ledger		
Requests to SBS to set up of New Suppliers	Band 5	
Sales ledger		
Approval of new customers within the finance system	Band 5	
Cash		
Banking and Receipting of all cash and cheques received by ICB	Band 5	
Setting any required Payment Run/Payroll Bank run ceiling and authorising payment when this is exceeded.	Band 8c	
Oracle users		
Amend user e.g., change of role (no approval limit change)	Band 8a	
Request for new user (financial approval limit required)	Band 8c	

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Technical and/or financial system related matters (2 of 2)

Responsibility	Minimum authorisation level	Notes
Delegated limits for budget virements (moving funding from one budget to another)		
Up to £1,000,000	Band 8d	This is where a budget is moved because the delegated responsibility has changed as opposed to budget journals within delegated responsibilities
Over £1,000,000 up to £10,000,000	Tier 2	
Over £10,000,000	Chief Finance Officer	
Release of funding held in reserves		
Up-to £20,000,000	Tier 2 - Director of Finance	In support of financial grip and control the financial plan may determine that certain funding is initially held in reserves. All in year allocations will be held in reserves until released. All reserve movements will be reported to the relevant Finance, Performance and Quality Committee
£20,000,001 and over	Chief Finance Officer	
Bank Accounts		
Opening bank accounts or procuring banking services in accordance with mandates approved by the Board	Chief Finance Officer	
Addition or removal of signatories to bank accounts	Chief Finance Officer, or authorised signatory to the bank accounts (in accordance with the bank account mandated authorities)	

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Staffing matters

Delegated matters	Minimum authorisation level	Notes
Staff costs		
Setting ICB funded establishment	Vacancy Approval Panel (appointed by Executive Committee)	This relates to all matters regarding approval of expenditure on staff related issues. In the case of incurring staff pay costs the relevant approval must be sought prior to any role being advertised.
Authority to fill posts within funded establishment (on payroll only - but may be permanent or fixed term)	Band 8d with confirmation that funding exists by the relevant finance manager/financial accountant/people partner Resource request process still followed to ensure finance and people partner engagement	
Authority to appoint staff to post not in the agreed establishment. (This requires the relevant management process to be followed)	Follow Resource Recruit process. Ultimately authorised by Vacancy Approval Panel (appointed by Executive Committee)	
Authority to authorise overtime (where allowable – i.e., in accordance with employee terms and conditions)	Band 8a	
All requests for upgrading / re-grading (dealt with in accordance with procedures)	Tier 1	
Approval of the extension of staff on fixed term contracts	Vacancy Approval Panel	
Before engagement of 'Off payroll' staff an employment status check must be undertaken in conjunction with HR. Engagement of 'off payroll workers needs to follow the procurement process and the contracts team must be included in the process from the outset. Early engagement with HR and finance teams is essential.		
'Off payroll' staff engagements below criteria set by NHSE	Chief People Officer and Chief Finance Officer	Note NHSE limits
'Off payroll' staff engagements –likely to exceed criteria set by NHSE	Chief Finance Officer or Tier 2 - Director of Finance - only after authorisation has been given by NHS England	
Leave		
Approval of Annual Leave, including carry forward (up to 5 days / over 5 days)	Line Manager	
Payment of Annual Leave in exceptional circumstances	Tier 1	
Compassionate leave up to 3 days	Line Manager	
Compassionate leave up to 10 days	Tier 1	
Special leave arrangements - up to 6 days in any one year	Tier 1	
Leave without pay	Tier 1	

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Capital Expenditure

Delegated matters	Minimum authorisation level	Notes
Agreement of Capital Project plan (prior to submission to NHSE)	Chief Finance Officer	Capital expenditure is expected to largely comprise plant and equipment. Expenditure is defined as capital in nature when plant and equipment are expected to be used for more than one year, and the cost is at least £5,000. Where items individually cost less than £5,000 but are more than £250 then they may be treated as group of assets and treated as capital. Clarification on the treatment should be confirmed with the finance team before incurring any expenditure. Funding is only confirmed by NHSE following their approval of a capital project
Approval of Capital project	NHS England	
Following the approval of the capital project, the procurement, contracting and subsequent authorisation of invoices follow the procedures outlined above		

Leases

Where the ICB is considering a lease where the lease term exceeds 12months and relates to property and/or equipment that is over £5,000 (if bought outright) then the impact**must** be assessed by the finance team. If it is determined that the lease creates a ‘right to use asset’ then the capital expenditure process needs to be followed as outlined above. Due to the technical nature of this the finance team must be engaged at the outset of the planning process as NHSE approval may need to be given prior to signing a lease.

Condemning and disposal

Delegated matters	Minimum authorisation level	Notes
Condemning or disposal of unserviceable items (other than IT equipment) with an estimated replacement cost:		
up to £100	Designated budget holder	
£101 to £5,000	Tier 2 - Director of Finance (Operations)	
£5,001 and above	Chief Finance Officer	
Condemning or disposal of all unserviceable IT equipment	Tier 1	

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Losses and Special Payments

Delegated matters	Minimum authorisation level	Notes
Losses and Special Payments:		There is no budgetary provision for losses and special payments and therefore these classes of expenditure are subject to more scrutiny including publication within the ICB's annual accounts. Losses should only be considered where all the facts have been appraised and that there is no alternative action for recovery. Special payments are only to be made where there is no suitable alternative remedy available. In all cases a 'Losses and special payments checklist' will need to be completed prior to approval being considered. Certain special payments require prior authorisation from NHSE regional/national team and/or HM Treasury. All losses and special payments will be reported to the Audit and Risk Committee.
Up to £5,000	Tier 2 - Director of Finance	
Over £5,000	Chief Finance Officer or Chief Executive Officer	
Write off of Bad Debts:		
Under £50,000	Chief Finance Officer	
Over £50,000	Chief Finance Officer and Chief Executive Officer	
Notification to SBS to action Write Offs	Financial Accountant – Band 8a	

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Non – Financial

Delegated matters	Minimum authorisation level	Notes
Sealing of Documents	Chief Executive Officer and Chief Finance Officer	
Delegation of Duties not retained or reserved elsewhere.		
Exercise or delegation of those functions of NHS Devon ICB which have not been retained as reserved by the Board, other Committee or (specified) member or employee.	Chief Executive Officer	
Management of risk Ensuring the ICB has a risk management policy/framework and a programme in place.	Chief Executive Officer and Company Secretary	
Management of Insurance Ensuring the ICB has arrangements in place for the provision of adequate insurance cover for the ICB that is not indemnified through the NHS Resolution	Chief Executive Officer and Chief Finance Officer	
Signing non-legally binding administrative arrangements	Tier 1	

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Governance Handbook

Document	Governance Handbook
Version	V1 Draft Review
Senior Responsible Officer	Company Secretary
Author	H Braid, V Williams, K Kingan
Approved by:	NHS Cornwall and Isles of Scilly Integrated Care Board
Date approved:	28 May 2026
Date Issued	01 June 2026
Next Review Date	By 31 March 2027

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Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Contents

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Section 1 – Introduction and Overview

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1.1 Purpose of the Governance Handbook

This Governance Handbook brings together a range of documents which supports the NHS Devon Integrated Care Board (ICB) Constitution and promotes good corporate governance.

Corporate governance regulates the power and decision making of the people who have been given responsibility for the stewardship of public assets and healthcare services. In NHS Devon good corporate governance will protect both patients and public funds. It exists to ensure that decision-making is lawful, that statutory and wider legal and regulatory duties are met, and that decision-making is enhanced in terms of quality and scrutiny.

This Governance Handbook sets out in detail the corporate governance arrangements that support the implementation of the NHS Devon Constitution. It contains practical procedural details for applying the Constitution, including:

- Terms of Reference for Board Committees
- Scheme of Reservation and Delegation
- Functions and Decision Map
- Standing Financial Instructions and
- Other key policy documents.

In September 2025, NHS Cornwall and Isles of Scilly and NHS Devon established joint working arrangements as part of national NHS reforms to reduce the running costs of integrated care boards. The corporate governance arrangements supporting this new joint way of working, referred to as a “Cluster”, are also set out in this Handbook.

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In short, the Handbook is a collection of key documents and underpinning policies, designed to promote good corporate governance.

If there is any ambiguity between the NHS Devon Constitution and this Handbook, the Constitution will prevail.

1.2 NHS Core Values

The NHS Core Values are set out in the NHS Constitution:

Working together for patients:
Patients come first in everything we do. We fully involve patients, staff, families, carers, communities and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.

Respect and dignity:
We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.

Commitment to quality of care:
We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.

Compassion:
We ensure that compassion is central to the care we provide and respond to each person's pain, distress, anxiety, or need with humanity and kindness. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.

Improving lives:
We strive to improve health and wellbeing and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.

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Everyone counts:
We maximise our resources for the benefit of the whole community and ensure nobody is excluded, discriminated against, or left behind. We accept that some people need more help, that difficult decisions have to be taken, and that when we waste resources, we waste opportunities for others.

1.3 The Nolan Principles

The Committee on Standards in Public Life (Nolan Committee) set out in 1995 seven principles of public life which should apply to all in public service (The First Report of the Committee on Standards in Public Life, 1995). These principles have been adopted as the basis for NHS Devon's working practices. It is expected that all our staff and all members of the NHS Devon Board recognise and uphold them at all times.

Selflessness:
Holders of public office should act solely in terms of the public interest.

Integrity:
Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

Objectivity:
Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

Accountability:
Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

Openness:
Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

Honesty:
Holders of public office should be truthful.

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Leadership:
Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

1.4 Management and Leadership Code of Practice

Like the other Boards of NHS partners within the One Devon Integrated Care System, the NHS Devon Board has agreed to adopt NHS England's Management and Leadership Code of Practice. This code of practice outlines the core values, guiding principles, and characteristic behaviours expected of every leader and manager working within health and social care. It aims to support the professionalisation of management and leadership within these sectors. The core values set out in this framework are:

Accountability Owning your actions and decisions, learning from your mistakes and holding yourself and your colleagues to account, in order to achieve the best possible outcomes and experiences for service users of the health and care sectors.	**Integrity** Being a role model through your actions and behaviours, even in complex and challenging situations, while demonstrating honesty, transparency, and the highest ethical standards to remain true to yourself, your colleagues, your organisation, and the people you serve.	**Compassion** Embracing a people-centred approach in your actions, balancing empathy, kindness, and thoughtfulness toward others with professional boundaries, and ensuring safety, dignity and respect for individual autonomy and rights.
Collaboration Encouraging strong teamwork and transdisciplinary cooperation to maximise expertise and resources across professional, team, organisational, and system boundaries, integrating diverse skills and experiences to achieve shared goals.	**Inclusion** Exemplifying and promoting equity, diversity, belonging, and ethical practice for all by fostering a safe organisational culture that actively challenges situations that are not inclusive, such as bullying, harassment, disrespectful behaviour or discrimination.	**Curiosity** Empowering individuals to embrace a spirit of inquiry that welcomes innovation and challenges ways of working, in order to keep practices and processes current, and drive incremental and transformational change and development.

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Section 2 – ICS Governance Framework

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2.1 Statutory Framework for Integrated Care Systems

NHS Devon

Integrated Care Systems (ICSs) are partnerships of organisations that come together to plan and deliver joined-up health and care services, and to improve the lives of people who live and work in their area. Following the Health and Care Act (2022), 42 ICSs were established across England on a statutory basis on 1 July 2022.

Each ICS includes:

- An **Integrated Care Partnership (ICP)** – a statutory committee jointly formed between the NHS Integrated Care Board and all upper-tier local authorities that fall within the ICS area. The ICP brings together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally. The ICP is responsible for developing an integrated care strategy to meet the health and wellbeing needs of the population in the ICS area.

- An **Integrated Care Board (ICB)** – a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area.

- **local authorities** in the ICS area, which are responsible for social care and public health functions as well as other vital services for local people and businesses,

- **place-based partnerships** which lead the detailed design and delivery of integrated services across their localities and neighbourhoods. The partnerships involve the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers, representatives, and other community partners who support the health and wellbeing of the population.

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- **Provider collaboratives**, which bring providers together to achieve the benefits of working at scale across multiple places and one or more ICSs, to improve quality, efficiency and outcomes and address unwarranted variation and inequalities in access and experience across different providers

2.2 The purpose of Integrated Care Systems

NHS Devon

The **purpose** of Integrated Care Systems (ICSs) is to bring partner organisations together to:

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

Collaborating as an ICS will help health and care organisations tackle complex challenges, including:

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

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2.3 One Devon Integrated Care System (1 of 2)

The Devon ICS, or One Devon, covers the geographical footprint of the three local authorities in Devon, Plymouth and Torbay, with a population of 1.6 million people.

The four **Statutory Partners** in the One Devon Integrated Care System:

- NHS Devon Integrated Care Board
- Devon County Council
- Plymouth City Council
- Torbay Council

The six **NHS Provider Partners** in the One Devon Integrated Care System are:

- Devon Partnership NHS Trust
- Royal Devon University Healthcare NHS Foundation Trust
- Torbay and South Devon NHS Foundation Trust
- University Hospitals Plymouth NHS Trust
- South Western Ambulance Service NHS Foundation Trust
- Livewell Southwest

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2.3 One Devon (2 of 2)

The **Primary Care Partners** in the One Devon Integrated Care System are:

- 116 GP Practices in 31 Primary Care Networks and 190 Pharmacies in Devon
- 23 GP Practices in 6 Primary Care Networks and 46 Pharmacies in Plymouth
- 10 GP Practices in 3 Primary Care Networks and 28 Pharmacies in Torbay

A wide range of other **Voluntary, Community and Social Enterprise Partners** also provide health and care services in Devon.

In Devon, a conscious decision has been taken to replace the three letter acronyms in the Health & Care Act with names that are more descriptive of the purpose of each component part of the governance arrangements in Devon:

- The ICS is known as **One Devon, the One Devon Integrated Care System** or ‘the system’
- The ICP is known as the **One Devon Integrated Care Partnership**
- The ICB is known as **NHS Devon**

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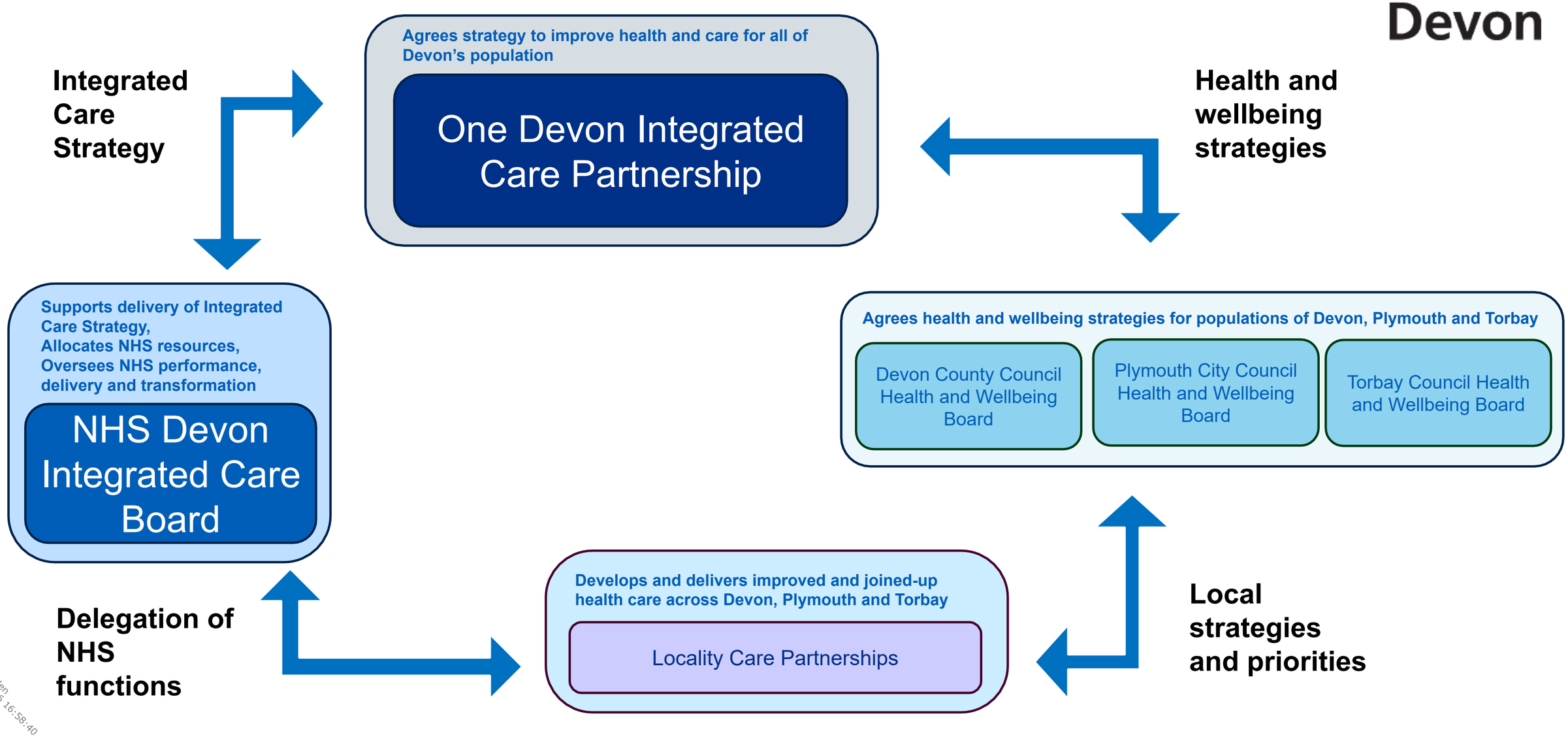
2.4 Functions and Decisions Map



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Section 3 – The One Devon Integrated Care Partnership

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3.1 One Devon Integrated Care Partnership – core purpose

The One Devon Integrated Care Partnership has been jointly established by NHS Devon, Devon County Council, Plymouth City Council and Torbay Council as a Joint Committee in accordance with the Constitutions of each statutory organisation.

The core purpose of the One Devon Integrated Care Partnership is to generate an integrated care strategy to reduce health and care inequalities, improve wellbeing, health and care access outcomes and service experiences for people across Devon.

All One Devon partners are jointly accountable for making progress and delivering this strategy.

The One Devon Integrated Care Partnership will meet in public at least four times per year and is chaired by a member of the Partnership who has been approved by all members.

The conclusions from each meeting of the One Devon Integrated Care Partnership are reported to NHS Devon.

Terms of reference for the One Devon Integrated Care Partnership

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3.2 One Devon Integrated Care Partnership - membership

Sector	Role
NHS Devon (ICB)	• Chair, NHS Devon • Chief Executive Officer, NHS Devon • Non-Executive Member
Health and Wellbeing Boards	• Chair, Devon Health and Wellbeing Board • Chair, Plymouth Health and Wellbeing Board • Chair, Torbay Health and Wellbeing Board
Provider Collaboratives	• Director, NHS Acute Provider Collaborative • Director, Mental Health Learning Difficulties Neurodiversity Collaborative
Integrated Care System	• Chair, Clinical and Professional Cabinet and Clinical Senate
Local Care Partnerships	• Representative, Local Care Partnership North • Representative, Local Care Partnership East • Representative, Local Care Partnership West • Representative, Local Care Partnership South • Representative, Local Care Partnership Plymouth
Local Authorities	• Director of Adult Services • Director of Children's Services • District Council Representative
Voluntary Sector	• 3 x Representative, Voluntary, Community and Social Enterprise
Healthwatch	• Representative, Healthwatch Devon, Plymouth and Torbay
Health Inequalities	• System Senior Responsible Officer, Health Inequalities
Primary Care	• Representative, Primary Care

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3.3 One Devon Integrated Care Strategy

Section 116ZB of the Health & Care Act confers a responsibility upon the One Devon Integrated Care Partnership to develop an integrated care strategy for the Devon population using best available evidence and data, covering health and social care (both children's and adults' social care), and addressing the wider determinants of health and wellbeing.

The strategy sets out how the assessed needs of our population are to be met by the exercise of functions of NHS Devon, NHS England, or the responsible local authorities whose areas coincide with or fall wholly or partly within its area.

The One Devon Five-year Integrated Care Strategy is focused on:

- Improving outcomes in population health and healthcare
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS support broader social and economic development

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Section 4 – The Integrated Care Board: NHS Devon

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4.1 NHS Devon Integrated Care Board – core purpose

NHS Devon took on the functions of NHS Devon Clinical Commissioning Group (CCG) on 1 July 2022, as well as broader strategic oversight of joined-up health and care delivery across Devon.

Core purpose: to agree the strategic priorities and resource allocation for all NHS organisations in Devon and then lead the improvement and integration of high-quality health and care services for all communities across Cornwall & Isles of Scilly.

Key decisions made by NHS Devon include:

- approval of the NHS Devon five-year delivery plan (known as the Joint Forward Plan (JFP)) to address the prioritised health needs and integrated care strategy agreed by the Integrated Care Partnership
- approval of the strategic commissioning arrangements for acute, community health, mental health, primary care and urgent care services Devon.
- approval of the resource allocation for each NHS provider of acute, community health, mental health, primary care and urgent care services in Devon.
- approval of major system-wide investment programmes to integrate and transform health and care services across the region.
- constructive support and challenge of the NHS Devon Chief Executive Officer and Executive on the actions being taken to deliver the strategic objectives and financial performance of NHS Devon

NHS Devon holds public meetings at least twice a year, chaired by the Chair of NHS Devon.

NHS Cornwall and Isles of Scilly and NHS Devon established joint working arrangements in September 2025, as part of national NHS reforms which required some ICBs with smaller populations, including NHS Cornwall and Isles of Scilly and NHS Devon, to work more closely with other ICBs in a 'Cluster'. 'Clustering' means that, although both individual ICBs continue to exist, they work as one – with a single Board, leadership team and staffing structure. Both organisations will continue to be individual sovereign legal entities until the point of formal merger (expected April 2027).

To ensure effective and cohesive governance oversight of the Cluster arrangements, both organisations have delegated their current Board's responsibilities into a joint committee arrangement – the South West Peninsula Board. The cluster Board is chaired by John Govett and includes executive and non-executive members from across both counties.

Public Health
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4.2 NHS Devon Integrated Care Board - membership and meetings (1of 2)

Integrated Care Boards (ICBs) are statutory organisations (established 1 July 2022) that bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnerships across the ICS.

The membership of the ICB for Devon is set out in the ICB's Constitution and comprises the following roles:

- Chair
- Chief Executive
- Four Partner Members comprising:
  - One Partner Members for NHS Trusts and Foundations Trusts
  - One Partner Member for primary medical services
  - One Partner Member for local authorities
  - One Partner Member for mental health
- At least five and up to six Non-Executive Members
- Six Executive Members:
  - Chief Finance Officer
  - Chief Strategic Planning and Commissioning Officer
  - Chief Clinical Officer (Chief Nursing Officer)
  - Chief Place and Transformation Officer (Chief Medical Officer)
  - Chief Population Health Officer
  - Chief People Officer

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The Board has also invited a number of participants and attendees to take part in its meetings.

4.2 NHS Devon Integrated Care Board - membership and meetings (2 of 2)

John Govett - Chair (Non-Executive)

Philippa Harding - Company Secretary

Non-Executive Members

Graham Clarke
Tarn Lamb
Lopa Patel
Martin Sykes
Neil Walden
Robert Williams

Executives

Mark Hackett - Chief Executive (and Accountable Officer)

Susan Bracefield – Chief Clinical Officer (CNO)

Peter Collins – Chief Population Health Officer

Simon Gittoes-Davies - Chief Finance Officer

Chris Reid – Chief Place and Transformation Officer (CMO)

Libby Ryan-Davies - Chief Strategic Planning and Commissioning Officer

Patrick Weir – Chief People Officer

Partner Members

Dr Frank O'Kelly
Primary Care Medical Services

Sam Higginson
NHS Providers

Anne-Marie Bond
Local Authorities

Phill Mantay
Mental Health

Board meets twice a year minimum

Key:

Board Ordinary Members

Board Participants

Board Attendees

Pete Roberts
GP Collaborative

Diana Crump
VCSE Assembly

Lincoln Sargeant
Local Authorities
(DPH)

NHS England South West (and others at Chair's discretion)

Brad Dixon
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4.3 NHS Devon Integrated Care Board – statutory duties (1of 2) NHS Act 2006

Duty to develop, publish and update annually a Joint Forward Plan (JFP) Sections 14Z52, 14Z53, 14Z54	**Duties as to reducing inequalities in access and outcomes** Section 14Z35
Duty to develop a joint capital resource use plan Section 14Z56	**Duty as to patient choice** Section 14Z37
Financial duty as to resource use limits Section 223M	**Duty to obtain appropriate advice** Section 14Z38
Duty of co-operation between NHS bodies and local authorities Section 82	**Duty to promote innovation** Section 14Z39
Public involvement duty Section 14Z45	**Duty in respect of research** Section 14Z40
Duty of ICBs to commission certain health services Section 3	**Duty to promote education and training** Section 14Z41
Duty to promote the NHS Constitution Section 14Z32	**Duty as to promoting integration** Section 14Z42
Duty as to effectiveness, efficiency and economy Section 14Z33	**Duty to have regard to the wider effect of decisions (the Triple Aim)** Section 14Z43
Duties as to improvement in quality services Section 14Z34	**Duties as to climate change** Section 14Z44

Braid Healthcare
21/05/2024 16:57:00

4.3 NHS Devon Integrated Care Board – statutory duties (2 of 2) other key statutory duties

Duty to establish an Integrated Care Partnership (ICP)	Sections 116ZA, 116ZB, 116B Local Government and Public Involvement in Health Act 2007
Public Sector Equality Duty ('PSED')	Section 149, Equality Act 2010
Duty to have regard to the NHS Constitution	Section 2, Health Act 2009
Duty to have regard to assessments and strategies	Section 116B, Local Government and Public Involvement in Health Act 2007

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4.4 NHS Devon Integrated Care Board – statutory functions

- Developing a plan to meet the health and healthcare needs of the population, having regard to the One Devon ICP's integrated care strategy.
- Allocating NHS resources to deliver the plan across the system, determining what resources should be available to meet population need in each place and setting principles for how they should be allocated across services and providers (both revenue and capital).
- Establishing joint working arrangements with partners that embed collaboration as the basis for delivery within the plan.
- 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.
- Arranging for the provision of health services in line with the allocated resources across the ICS.
- Leading system implementation of people priorities including delivery of the People Plan and People Promise.
- 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.
- 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.
- Ensuring that the NHS play a full part in achieving wider goals of social and economic development and environmental sustainability
- Driving 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.
- 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 co-ordination responsibilities as delegated by NHS England.
- Exercising commissioning functions to be delegated by NHS England including commissioning of primary care and appropriate specialised services.

Board Meeting
21/05/2026 10:58:46

4.5 Delegated direct commissioning functions

In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England has delegated the exercise of certain delegated functions to NHS Devon to empower it to commission a range of services for the people of Devon.

These delegated functions are the functions are as follows:

- Specialised services
- Primary medical services
- Primary dental services and prescribed dental services
- Primary ophthalmic services
- Pharmaceutical services and local pharmaceutical services

Further information about these delegated functions can be found later in this document.

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4.6 Supra ICS governance arrangements

NHS Devon

To deliver some of its functions, NHS Devon needs to work together with other ICBs; for example, commissioning more specialised services, emergency ambulance services and other services where relatively small numbers of providers serve large populations, and when working with providers that span multiple ICSs or operate through clinical networks.

The governance arrangements that support these joint working arrangements are known as “supra-ICS” and are co-designed by the parties working together.

NHS Devon participates in the following supra-ICS governance arrangements:

Pharmacy, Optometry and Dentistry (POD) Committees in Common
The ICBs across the South West have determined they will work collaboratively to discharge their delegated commissioning responsibility for the delivery of POD services. The Committees in Common approach is being employed to allow organisations to take aligned decisions together on programmes that cross organisational/geographical boundaries.

Ambulance Partnership Board
The Ambulance Partnership Board brings together the ICBs across the South West and South Western Ambulance NHS Foundation Trust (SWASFT) to discuss the most pressing challenges, set the direction of strategic plans that take into account both provider and ICB strategy/plans, as well as demonstrating oversight and assurance of SWASFT as outlined in the NHS Oversight Framework.

South West Joint Specialised Services Committee
NHS England and the ICBs in the South West have formed a statutory Joint Committee to collaboratively make decisions on the planning and delivery of joint specialised services, to improve health and care outcomes and reduce health inequalities. The Joint Committee provides strategic decision-making, leadership and oversight for the commissioning of Specialised Services and any associated activities.

Brad Alison
21/05/2026 08:40

4.7 Constitution and Standing Orders, Scheme of Reservation and Delegation, Standing Financial Instructions and key policy documents (1 of 4)

There are several key documents that form the core of the NHS Devon corporate governance framework.

These are its:

- **Constitution and Standing Orders**
- **Scheme of Reservation & Delegation (SoRD)**
- **Standing Financial Instructions**
- **Key Policy Documents**

The following pages provide a brief summary of each document's purpose and links to that document.

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4.7 Constitution and Standing Orders, Scheme of Reservation and Delegation, Standing Financial Instructions and key policy documents (2 of 4)

Constitution and Standing Orders

- The NHS Devon ICB Constitution articulates the fundamental principles underpinning the way in which it will operate. It sets out the authority with which the NHS Devon can act and how it will organise itself to exercise its functions.

- The Constitution contains the Standing Orders which set out clear procedures for conducting the Board's business and other key meetings. They cover how meetings should be convened and chaired; how agendas and supporting papers should be prepared and circulated; how decisions should be made; and how they should be recorded.

- The ICB will review its Constitution each year to make sure that it remains appropriate (although amendments can also be made outside this annual review process). Any proposed amendments will be considered by the Board of the NHS Cornwall and Isles of Scilly before being submitted to NHS England for final approval.

- NHS Devon has committed to taking account of the views of its partners before asking NHS England to approve any changes to its Constitution.

Brad,Helen
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Access the NHS Devon Constitution

4.7 Constitution and Standing Orders, Scheme of Reservation and Delegation, Standing Financial Instructions and key policy documents (3 of 4)

Scheme of Reservation & Delegation (SoRD)

To be clear about what has and hasn't been delegated, NHS Devon has agreed a Scheme of Reservation & Delegation (SoRD). The SoRD sets out:

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

Access the NHS Devon Scheme of Reservation and Delegation (SoRD)

Standing Financial Instructions

The Board has agreed on a set of Standing Financial Instructions (SFIs) that include the delegated financial authority limits set out in the SoRD. SFIs are designed to ensure regularity and propriety of financial transactions. SFIs define the purpose, responsibilities, legal framework and operating environment of NHS Devon.

Access the NHS Devon Standing Financial Instructions

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4.7 Constitution and Standing Orders, Scheme of Reservation and Delegation, Standing Financial Instructions and key policy documents (4 of 4)

Key Policy Documents

NHS Devon has also agreed on several key policies which determine how the Board and staff members should go about their business:

Standards of Business Conduct Policy	Conflicts of Interest Policy	Policy for Public Involvement and Engagement	Policy for the Development of Procedural Documents
This policy, which should be read in conjunction with the Conflicts of Interest Policy, sets out the arrangements that will be made to ensure the highest standards of corporate behaviour and responsibility from NHS Devon Board members, staff and decision-making groups. It indicates NHS Devon's expectations in relation to declarable interests, charitable collections, political activities and personal conduct (including corporate responsibilities, use of social media, confidentiality, gambling, lending and borrowing, trading on official NHS premises, insolvency and arrest or conviction). It sets out how to raise concerns about breaches of the policy and the implications of failure to comply with the policy.	This policy provides definitions of the different types of conflicts of interest which exist (financial, non-financial professional, non-financial personal, and indirect interests). It also highlights the roles and responsibilities of key individuals within NHS Devon with regard to the management of conflicts of interest. It dictates the actions to be taken in identifying, declaring and reviewing interests. It also sets out how information about interests will be published or withheld. It sets out how interests should be managed within meetings. It also explains the type of interests that should be declared (loyalty, gifts, hospitality, meals and refreshments, travel and accommodation, outside employment, shareholdings, patents, donations, clinical private practice). Arrangements to be made in relation to sponsorship and joint working are also included in the policy, as well as procurement and contract monitoring. It sets out how to raise concerns about breaches of the policy and the implications of failure to comply with the policy. It also sets out training requirements associated with the policy.	This policy (known as the people and communities framework) sets out how NHS Devon and the rest of the One Devon Integrated Care System will work together to understand the needs of Devon's changing population. It sets out the role of the Devon Engagement Partnership, which will be the vehicle that will support the governance and assurance that the ICS is effectively and meaningfully listening to and working with people and communities across Devon	This policy provides a definition of the different procedural documents within NHS Devon and it sets out the template to be adopted for NHS Devon policies. It sets out how new procedural documents should be developed and the approach to be taken to amending/ reviewing them. It highlights requirements in relation to impact assessments and the development of implementation plans to support strategies and policies. It also sets out consultation requirements to be fulfilled in advance of seeking approval for strategies and policies. The policy sets out the approval routes for NHS Devon procedural documents

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4.8 Non – Executive Member Roles and Responsibilities

NHS Devon and NHS Cornwall & Isles of Scilly are required to appoint individuals to certain key roles to comply with legislation and relevant guidance from NHS England and other organisations. Below is information about these roles:

- Senior Independent Director – **Tarn Lamb**
- NHS Cornwall and Isles of Scilly ICB Deputy Chair – **Martin Sykes**
- NHS Devon ICB Deputy Chair – **Graham Clarke**
- Conflict of Interest Guardian – **Lopa Patel**
- Health and Wellbeing Guardian – **Tarn Lamb**
- Champion for Equality, Diversity and Inclusion (EDI) – **Tarn Lamb**
- Champion for Accessibility Information Standard (AIS) – **Tarn Lamb**
- Champion for Freedom to Speak Up – **Lopa Patel**
- Champion for Emergency Planning, Preparedness and Resilience – **Martin Sykes**
- Champion for Environmental Sustainability – **Graham Clarke**
- Champion for children and young people with special educational needs and disabilities (SEND) – **Neil Walden**
- Champion for Children and Adult Safeguarding – **TBC**

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4.8 Executive Roles and Responsibilities

NHS Devon and NHS Cornwall & Isles of Scilly are required to appoint individuals to certain key roles to comply with legislation and relevant guidance from NHS England and other organisations. Below is information about these roles:

- **Senior Information Risk Owner (SIRO)** - Company Secretary
- **Caldicot Guardian** - Chief Place and Transformation Officer (CMO)
- **Lead for Equality, Diversity and Inclusion (EDI)** – Chief People Officer
- **Lead for Accessible Information Standard (AIS)** – Chief Population Health Officer
- **Lead for population health and equality** – Chief Population Health Officer
- **Lead for service equity** – Chief Population Health Officer
- **Lead for Health and Safety** - Company Secretary
- **Accountable Emergency Officer** (AEO) - Chief Clinical Officer (CNO)
- **Lead for Freedom to Speak Up** - Chief Clinical Officer (CNO)
- **Lead for Mental Health** - Chief Clinical Officer (CNO)
- **Lead for children and young people** (aged 0 to 25) - Chief Clinical Officer (CNO)
- **Lead for children and young people with special educational needs and disabilities** (SEND) - Chief Clinical Officer (CNO)
- **Lead for Down syndrome** (all-age) - Chief Clinical Officer (CNO)
- **Lead for learning disability and autism** (all-age) - Chief Clinical Officer (CNO)
- **Lead for Safeguarding** (all-age, including looked-after children and care leavers) – Chief Clinical Officer (CNO)
- **Lead for Maternity and Neonatal services** - Chief Clinical Officer (CNO)
- **Lead for Complaints and PALS** - Chief Clinical Officer (CNO)
- **Lead for Clinical and Quality Governance** - Chief Clinical Officer (CNO)
- **Lead for Infection Prevention and Control (IPC)** - Chief Clinical Officer (CNO)
- **Lead for Right Care Right Place** - Chief Clinical Officer (CNO)
- **Lead for Medicines Optimisation** - Chief Clinical Officer (CNO)
- **Counter Fraud Lead/Champion** - Chief Finance Officer
- **Lead for social and economic development** - Chief Place and Transformation Officer (CMO)
- **Lead for public and patient involvement** - Chief Strategic Planning and Commissioning Officer
- **Lead for Climate Change and Sustainability** – Chief Finance Officer

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4.9 Risk Management

NHS Devon recognises that risk management is a key organisational responsibility, integral to its governance arrangements and internal controls.

ICB Vision

NHS Devon's vision is for risk management to be embedded across all of NHS Devon's business activities and processes, promoting a risk-aware culture throughout the organisation.

This will be achieved by:

- Early identification, assessment, mitigation, reporting, and monitoring of risk, with sufficient resources available to manage the risk within tolerable levels.
- Comprehensive and consistent training for all staff within NHS Devon.

Purpose of Risk Management in the ICB

- Reduce the risk of harm to patients, staff, and stakeholders by proactively identifying, managing, prioritising, mitigating, and monitoring risks that threaten the delivery of NHS Devon's strategic and operational plans.
- Safeguard the essential values of NHS Devon by minimising or reducing the risk that impacts on the quality of care, patient safety, and a safe working environment, financial property, stakeholder relationships and operational reputation.
- Ensure NHS Devon acts lawfully and operates openly and transparently, reporting risks to the Board and committees.

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4.10 Risk Management Policy & Board Assurance Framework

NHS Devon's Risk Management Policy and **Board Assurance Framework** support NHS Devon's broader risk management framework and outline NHS Devon's approach to risk, including its risk appetite and tolerance.

The Risk Management Policy defines responsibilities for risk management and associated governance arrangements, including reporting to the board. Its purpose is to promote and embed best practice throughout the organisation and applies to all levels of risk. The policy facilitates a dynamic risk management approach, enabling the Board to remain focused on the highest-level risks and ensure that appropriate control mechanisms are in place.

Strategic risks are high-level threats that can impede NHS Devon's strategic objectives and statutory duties. These risks are overseen by Board members and managed by Committees, as outlined in the **Board Assurance Framework (BAF).**

The Board Assurance Framework ensures that NHS Devon has identified its strategic corporate risks and implemented effective systems, policies, and processes.

Furthermore, the Board Assurance Framework is essential to preparing the Governance Statement in the Annual Report and helps the Board fulfil its responsibility to maintain an effective internal control system.

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Section 5 - Board Assurance Committees

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NHS Devon has established two Board Committees to support the Board and the Executive in fulfilling their responsibilities. These Committees, which are statutory, are:

5.1 Remuneration Committee

5.2 Audit and Risk Committee

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5.1 Remuneration Committee

Membership
5 x Non-Executive Members, one of whom will be the Chair
NHS Cornwall and Isles of Scilly and Devon Cluster Chair

Purpose:

- Responsible for approving the remuneration and pay frameworks for all NHS Devon employees and Board members (excl the NHS Devon Chair whose remuneration is determined by NHS England) and for exercising the functions of NHS Devon relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006, by confirming NHS Devon Pay Policy, including adoption of any pay frameworks for all employees including senior managers/directors (including Executive and Non-Executive Members of the NHS Devon Board, although excluding the NHS Devon Chair), as well as any arrangement relation to the termination of their employment (including redundancy and non-disclosure agreements).

Key responsibilities:

- Determine all aspects of remuneration, including but not limited to salary (including any performance-related elements), bonuses, fees or allowances.
- Approve provisions for other benefits, including pensions (and the NHS Pension Scheme), relocation and cars
- Determine arrangements for termination of employment and other contractual terms and non-contractual terms
- Assess proper calculation and scrutiny of termination payments taking account of such national guidance as appropriate, advising on and overseeing appropriate contractual arrangements for such staff
- Assess proper calculation and scrutiny of any special payments
- Functions in relation to performance review/ oversight for directors/senior managers undertaken by the chief executive or their nominated deputy
- Consider and approve the annual review of the performance of the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chief Executive, conducted by the Cluster Chair
- Consider and approve the annual review of the performance of the executive directors conducted by the Cluster Chief Executive
- Succession planning for the NHS Devon Board
- Approve changes to the director structure when reliance on the organisational change policy is required
- Overseeing staff contractual arrangements.
- Approving proposals for termination payments and any special payments (including arrangements for dealing with legal cases relating to employment issues.
- Providing assurance with regard to the policy and process for the appointment of Co-opted Members of NHS Devon Board Committees.
- Providing assurance in relation to NHS Devon statutory duties relating to people such as compliance with employment legislation including such as Fit and Proper Person Regulation (FPPR) and conflicts of interest requirements

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5.2 Audit and Risk Committee

NHS Devon

Membership

3 x Non-Executive Members, one of whom will be the Chair

Purpose:

- To provide oversight and seek assurance on the adequacy of governance, risk management and internal control processes within the organisation. The Committee will also make recommendations on those areas of system audit or risk management where there is the biggest opportunity for improvement.

Key responsibilities:

- 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.
- 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.
- To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process.
- To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security).
- To assure the Board that internal governance processes are fit for purpose for the purposes of maintaining a sound system of internal control and are operating effectively.
- To receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.
- To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.
- To undertake a scrutiny and independent assurance oversight role in relation to the effectiveness of the systems and processes in place within the ICB in relation to emergency planning resilience and recovery (EPRR), including risk assessments, action plans and tests, to ensure the ICB fulfils its category 1 responder statutory requirements

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Section 6 – NHS Cornwall and Isles of Scilly and NHS Devon Cluster

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6.1 - South West Peninsula Board – core purpose

NHS Devon

NHS Cornwall and Isles of Scilly (CIOS) and NHS Devon Integrated Care Boards (ICBs) entered a Cluster arrangement on 01 September 2025.

Under Cluster arrangements, NHS Devon and NHS Cornwall and Isles of Scilly ICBs chose to delegate powers under a Joint Scheme of Reservation & Delegation (SoRD) to a Joint Committee, namely the South West Peninsula Board.

The purpose of the South West Peninsula Board is to enable both NHS CIOS and NHS Devon to enact their Cluster arrangement and take decisions as one in the best interests of the populations of Devon, Cornwall and the Isles of Scilly.

The South West Peninsula Board **meets in public at least six times per year** and is chaired by the Cluster Chair.

The South West Peninsula Board is supported by the following Committees:

- **Devon Finance, Performance and Quality Committee**
- **Cornwall and Isles of Scilly Finance, Performance and Quality Committee**
- **South West Peninsula Neighbourhood Health Improvement Committee**
- **South West Peninsula Planning Committee**
- **South West Peninsula People, Customer Experience and Equity Committee**
- **South West Peninsula Management Board**
- **Transition Steering Group**

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The Remuneration and Audit and Risk Committees of each ICB continue to meet,but will generally meet in common.

6.2 South West Peninsula Board – membership

Chair (Non-Executive)
John Govett

Company Secretary

NHS Cornwall and Isles of Scilly

NHS Devon

Non-Executive Members

Graham Clarke
Tarn Lamb
Lopa Patel
Martin Sykes
Neil Walden
Robert Williams

NHS Cornwall and Isles of Scilly

NHS Devon

Executives

Mark Hackett - Chief Executive (and Accountable Officer)

Susan Bracefield – Chief Clinical Officer (CNO)

Peter Collins – Chief Population Health Officer

Simon Gittoes-Davies - Chief Finance Officer

Chris Reid – Chief Place and Transformation Officer (CMO)

Libby Ryan-Davies - Chief Strategic Planning and Commissioning Officer

Patrick Weir – Chief People Officer

NHS Cornwall and Isles of Scilly

NHS Devon

Partner Members

Dr Smitesh Patel
Primary Care Medical Services (CIOS)

Dr Frank O'Kelly
Primary Care Medical Services (Devon)

Steve Wiliamson
NHS Providers Trusts (CIOS)

Sam Higginson
NHS Trusts and Foundation Trusts (Devon)

Alison Bulman
Local Authorities (CIOS)

Anne-Marie Bond
Local Authorities (Devon)

Debbie Richards
Mental Health (CIOS)

Phil Mantay
Mental Health (Devon)

Key:

Board Ordinary Members

Board Participants

Board Attendees

Stewart Smith
GP Collaborative – CIOS

Peter Roberts
GP Collaborative – Devon

Emma Rowse
VCSF – CIOS

Diana Crump
VCSE Assembly – Devon

Eunan O'Neill
Local Authorities (DPH) – CIOS

Lincoln Sargeant
Local Authorities (DPH) – Devon

NHS England South West and Devon ICP Chair (and others at Chair's discretion)

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6.3 Committees supporting the South West Peninsula Board

NHS Devon

Integrated Care Board
Chair: John Govett

- **Audit and Risk Committee** — Chair: Lopa Patel
- **Remuneration Committee** — Chair: Robert Williams
- **South West Peninsula Board** — Chair: John Govett

NHS Cornwall and Isles of Scilly

Integrated Care Board
Chair John Govett

- **South West Peninsula Board** — Chair: John Govett
- **Remuneration Committee** — Chair: Robert Williams
- **Audit and Risk Committee** — Chair: Lopa Patel

South West Peninsula Board — Chair: John Govett

South West Peninsula Neighbourhood Health Improvement Committee

Chair: Neil Walden

Seeks assurance on the movement of NHS services from hospitals to community-based settings and the objectives of improved patient outcomes and long term sustainability of the NHS by providing more care closer to people's homes.

South West Peninsula People, Customer Experience and Equity Committee

Chair: Tarn Lamb

Considers and seeks assurance on the experience of people (staff, patients and the public) in relation to the work of both ICBs ensuring the cluster seeks and acts on insights to improve equity within the NHS workforce and the delivery of health outcomes.

South West Peninsula Planning Committee

Chair: John Govett

Ensures both ICBs fulfil their obligations regarding the development of credible, integrated 5-year plans, demonstrating how financial sustainability will be secured over the medium term.

Focus: assurance of next year & 3 years

Devon Finance, Performance and Quality Committee

Chair: Graham Clarke

Oversees and seeks assurance on:

- Value for money from the use of public funding
- Delivery of performance targets
- Patients receiving safe, high-quality and timely healthcare with equal access to services and seamless handovers

Cornwall and Isles of Scilly Finance, Performance and Quality Committee

Chair: Martin Sykes

Oversees and seeks assurance on:

- Value for money from the use of public funding
- Delivery of performance targets
- Patients receiving safe, high-quality and timely healthcare with equal access to services and seamless handovers

Focus: assurance of in-year delivery

South West Peninsula Management Board

Chair: Mark Hacket

Supports and advises the CEO in the discharge of their executive and statutory functions

Transition Steering Group

Chair: John Govett

Oversee the establishment and implementation of Cluster and any future merger arrangements.

Executive Decision-Making

6.4 Devon Finance, Performance and Quality Committee

Membership
Deputy Chair, who will be the Chair of the Committee
up to 2 x Non-Executive Members
Chief Executive Officer

Purpose:

- Oversee and seek assurance that NHS Devon is maximising value for money from the use of its public funding and delivering its performance targets set out in the Operational Plan for the year.
- Oversee and seek assurance that patients are receiving safe, high-quality and timely healthcare with equal access to services and seamless handovers between different parts of the Devon system.

Key responsibilities:

- Seek assurance around the arrangements for discharging, and implications of, NHS Devon Integrated Care Board's responsibilities in relation to ensuring financial management achieves value for money, efficiency and effectiveness in the sustainable use of resources with a continuing focus on cost reduction, cost avoidance and achievement of efficiency targets (both financial and non-financial).
- Seek assurance around the arrangements for discharging, and implications of, NHS Devon Integrated Care Board's responsibilities in respect of quality of care, access and outcomes.
- Seek assurance around the arrangements for discharging NHS Devon Integrated Care Board's responsibilities in relation to securing continuous improvement in the quality of medical services.
- Monitor and assess NHS Devon Integrated Care Board's Board Assurance Framework (BAF)

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6.5 Cornwall and Isles of Scilly Finance, Performance and Quality Committee

Membership
Deputy Chair, who will be the Chair of the Committee
up to 2 x Non-Executive Members
Chief Executive Officer

Purpose:

- Oversee and seek assurance that NHS Cornwall and Isles of Scilly is maximising value for money from the use of its public funding and delivering its performance targets set out in the Operational Plan for the year.
- Oversee and seek assurance that patients are receiving safe, high-quality and timely healthcare with equal access to services and seamless handovers between different parts of the Cornwall system.

Key responsibilities:

- Seek assurance around the arrangements for discharging, and implications of, NHS Cornwall and Isles of Scilly Integrated Care Board's responsibilities in relation to ensuring financial management achieves value for money, efficiency and effectiveness in the sustainable use of resources with a continuing focus on cost reduction, cost avoidance and achievement of efficiency targets (both financial and non-financial).
- Seek assurance around the arrangements for discharging, and implications of, NHS Cornwall and Isles of Scilly Integrated Care Board's responsibilities in respect of quality of care, access and outcomes.
- Seek assurance around the arrangements for discharging NHS Cornwall and Isles of Scilly Integrated Care Board's responsibilities in relation to securing continuous improvement in the quality of medical services.
- Monitor and assess NHS Cornwall and Isles of Scilly Integrated Care Board's Board Assurance Framework (BAF)

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6.6 South West Peninsula Neighbourhood Health Improvement Committee

Membership
3 x Non-Executive Members, one of whom will be the Chair, and another will be the deputy.
Chief Place and Transformation Officer (Chief Medical Officer) Chief Population Health Officer Chief Strategic Planning and Commissioning Officer

Purpose:

- The South West Peninsula Neighbourhood Health Improvement Committee (the Committee) has been established by South West Peninsula Board to enable NHS Cornwall and the Isles of Scilly Integrated Care Board and NHS Devon Integrated Care Board (the Partner ICBs) to seek assurance with regard to the movement of NHS services from hospitals to community-based settings (including wider community services as well as Integrated Neighbourhood Teams) and the objectives of improved patient outcomes and the long-term sustainability of the NHS by providing more care closer to people's homes

Key responsibilities:

- Seek assurance with regard to the progress being made across the Cluster with regard to the shift to community based care, through the move of activities and services from hospitals to settings closer to patients, primarily within primary and community services.
- Seeking assurance with regard to the improvement of health outcomes and the reduction of health inequalities.
- Oversee the implementation of strategies to promote healthier lives and reduce the burden of illness, shifting from a reactive model to one focused on proactive health and well-being.
- Seek assurance with regard to the use of digital technologies to give patients more control and choice, improve access to care, and create a comprehensive digital patient record shared across the system.
- Seek assurance of the delivery of patient centred care
- Seek assurance that resources and services are being targeted to improve healthcare outcomes for all communities, with a particular focus on those experiencing health inequalities.

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6.7 South West Peninsula Planning Committee

Membership
Chair, NHS Cornwall and Isles of Scilly and NHS Devon Cluster (Committee Chair)
Deputy Chair, NHS Cornwall and Isles of Scilly Deputy Chair, NHS Devon 4x NHS Devon and NHS Cornwall ICBs Non-Executive Members
Interim Chief Executive Chief Finance Officer Chief Strategic Commissioning and Planning Officer Chief Clinical Officer (Chief Nursing Officer) Chief People Officer Chief Population Health Officer Chief Place and Transformation Officer (Chief Medical Officer)

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Purpose:

- Enable NHS Cornwall and the Isles of Scilly Integrated Care Board and NHS Devon Integrated Care Board (the Partner ICBs) to fulfil their obligations regarding the development of credible, integrated five-year plans, demonstrating how financial sustainability will be secured over the medium term.

- The Committee will enable the Partner ICBs to agree the “next year” at a monthly level and the following two years at a quarterly level, having gained in principle high-level agreement on plans (financial and quality) with NHS system providers by the end of December each year, ready to start from 1 April each year

- This means providing assurance to the South West Peninsula Board that the plans being developed by the Partner ICBs will:

    - build and align across time horizons, joining up strategic and operational planning
    - are coordinated and coherent across organisations and different spatial levels
    - demonstrate robust triangulation between finance, quality, activity and workforce

Key responsibilities:

- Oversee and coordinate the strategic and operational planning processes of the Partner ICBs for the “next year” and the medium term (including Medium Term Financial Plans (MTFPs)). This planning responsibility includes seeking assurance about the implementation of inclusive, collaborative and fit-for-purpose planning processes and approaches, as well as effective and robust planning outcomes that will lead to agreement of commissioning intentions and budgets

6.8 South West Peninsula People, Customer Experience and Equity Committee

Membership
3 x Non-Executive Members, one of whom will be the Chair, and another will be the Deputy Chair of the Committee)
Chief People Officer Chief Population Health Officer Chief Clinical Officer (Chief Nursing Officer)
Director of Adult Social Care

- **Purpose:**

Enable NHS Cornwall and the Isles of Scilly Integrated Care Board and NHS Devon Integrated Care Board (the Partner ICBs) to consider and seek assurance in respect of the experiences of people (staff, patients and the public) in relation to the work of the Partner ICBs, ensuring that the Cluster seeks and acts on insights to improve equity within the NHS workforce and the delivery of health outcomes.

Key responsibilities:

- Provide assurance that public involvement activities are being carried out effectively and meet the statutory duties placed on each ICB.
- Ensure equality and patient experience and feedback is embedded throughout the work of both NHS Cornwall and Isles of Scilly and NHS Devon and the integrated care systems of which they are a part.
- Provide assurance on the workforce recruitment, development and retention and wellbeing plans across the Cluster.
- Provide assurance around the arrangements for discharging, and implications of, responsibilities in respect of the preventing ill health and reducing inequality.
- Provide assurance of the delivery of the population health outcomes, including using benchmarking against other systems
- Ensure plans identify and engage the most marginalised communities in setting, delivering and monitoring health inequality priorities

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6.9 South West Peninsula Management Board

Membership
Chief Executive Officer (Chair)
Chief Finance Officer
Chief Clinical Officer (CNO)
Chief Place and Transformation Officer (CMO)
Chief Strategic Commissioning and Planning Officer
Chief Population Health Officer
Chief People Officer

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Purpose:

- To support and advise the Chief Executive Officer (CEO) of NHS CIOS and NHS Devon ICB Cluster in the discharge of their executive and statutory functions.

Key responsibilities:

- Formulate and recommend strategies (ensuring that they have appropriate detail with regard to delivery to enable ongoing Board assurance in respect of this.) for the South West Peninsula Board in the development of its business, having regard to the interests of the populations of both CIOS and Devon.
- Recommend high level budgets and financial plans to be agreed by the South West Peninsula Board and, following their adoption, ensure the achievement of these budgets and plans that are monitored and assured at Board Assurance Committees.
- Monitor performance and take action to ensure targets, objectives and key performance indicators are delivered as agreed by the South West Peninsula Board.
- Agree and keep under review the budgets for the different teams within NHS CIOS and NHS Devon Cluster to ensure that they fall within agreed targets.
- Optimise the allocation and adequacy of NHS CIOS and NHS Devon resources.
- Deliver commissioning intentions to ensure the NHS 10 Year Plan
- Ensure delivery of the proposed merger of NHS Cornwall and Isles of Scilly and NHS Devon
- Provide effective leadership within the CIOS and One Devon Integrated Care Systems to ensure delivery of the South West Peninsula Board's strategic objectives.
- Provide assurance to the South West Peninsula Board around the arrangements for discharging, and implications of, NHS CIOS and NHS Devon responsibilities in respect of the NHS Oversight Framework.
- Ensure appropriate levels of authority are delegated to senior management throughout NHS CIOS and NHS Devon.
- Ensure the provision of adequate management development and succession planning.
- Ensure the organisational structure of the NHS CIOS and NHS Devon Cluster is fit for purpose, with highly performing teams which operate together effectively.
- Ensure the control, co-ordination and monitoring within the NHS CIOS and NHS Devon Cluster of risk and internal controls.
- Ensure compliance with relevant legislation and regulations.
- Safeguard the integrity of management information and financial reporting systems.

6.10 Transition Steering Group

Membership
Chair, NHS Cornwall and Isles of Scilly and NHS Devon Cluster (Committee Chair)
Chief Executive Officer, NHS Cornwall and Isles of Scilly and NHS Devon Cluster
Non-Executive Member, NHS Cornwall and Isles of Scilly and NHS Devon Cluster
Chief Finance Officer
Chief People Officer

Purpose:

- Oversee the establishment and implementation of Cluster arrangements between NHS Devon and NHS Cornwall and the Isles of Scilly (CIOS) Integrated Care Boards (the ICBs) in the first instance. Once the organisational changes required to support the Cluster arrangement have been completed, the TSG will oversee the work required to ensure readiness for the formal merger of the ICBs on 01 April 2027.

Key responsibilities:

- Develop and approve the overall transition strategy and implementation plan
- Monitor progress against key milestones and deliverables
- Escalate significant risks or issues to the South West Peninsula Board (the joint committee established by NHS CIOS and NHS Devon Integrated Care Boards to enable the Cluster)
- Ensure alignment with NHS England's Model ICB Blueprint and clustering guidance
- Oversee the development of new governance structures for the Cluster
- Ensure legal and regulatory compliance throughout the transition
- Coordinate with NHS England on approval processes and reporting requirements
- Oversee the integration of operational functions and systems
- Monitor the establishment of shared leadership arrangements
- Ensure continuity of services during the transition period
- Approve arrangements for shared back-office functions and support services
- Oversee the financial aspects of the clustering arrangement
- Monitor achievement of required cost reductions
- Ensure financial controls and reporting mechanisms are maintained
- Approve budget allocations for transition activities
- Oversee workforce planning and staff consultation processes
- Monitor staff engagement and wellbeing during transition
- Ensure appropriate support for affected staff members
- Approve communications and engagement strategies
- Ensure patient safety and quality of care are maintained throughout the transition
- Monitor impact on service delivery and patient outcomes
- Oversee risk management processes during the transition period

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Section 7 – One Devon System Governance Arrangements

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7.1 Integrated Care System governance and assurance structures

7.2 One Devon System Leadership Group

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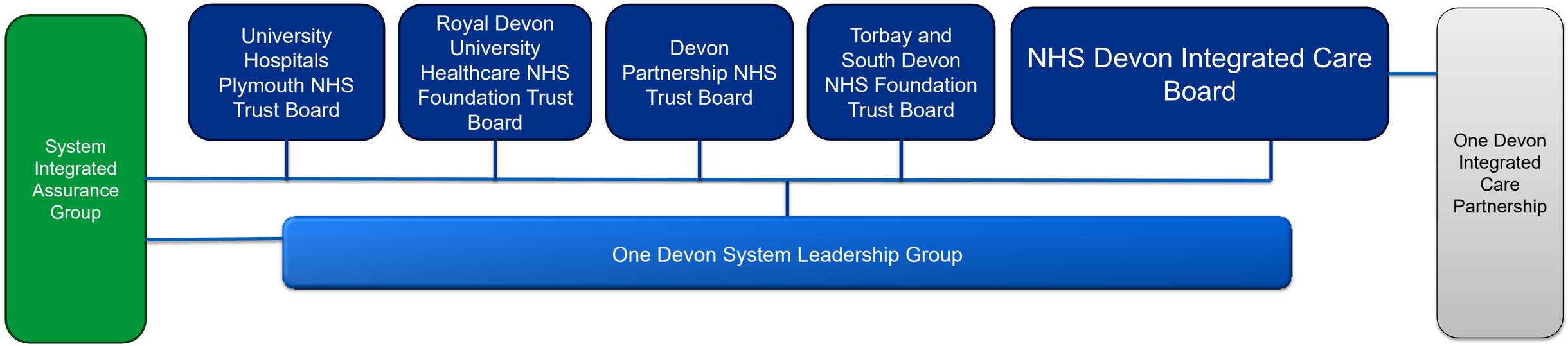
7.1 Integrated Care System governance and assurance structures



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7.2 System Leadership Group

Membership
NHS Devon CEO (Chair)
NHS Devon Chief Strategic Commissioning and Planning Officer (Vice Chair)
Devon Partnership NHS Trust CEO
Devon Partnership NHS Trust COO
Torbay and South Devon NHS Foundation Trust CEO
Torbay and South Devon NHS Foundation Trust COO
University Hospitals Plymouth NHS Trust CEO
University Hospitals Plymouth NHS Trust COO
Royal Devon University Healthcare NHS Foundation Trust CEO
Royal Devon University Healthcare NHS Foundation Trust COO
South Western Ambulance Service NHS Foundation Trust CEO
Primary Care representative – tbc

Purpose:

- To provide system-level leadership in the delivery of system recovery, the Joint Forward Plan, and other agreed system priorities.

Key responsibilities:

- Oversee the delivery of the criteria identified by NHS England for the exit of the One Devon Integrated Care System from Segment 4 of the NHS Oversight Framework.
- Oversee the development of the NHS-led aspects of the One Devon Integrated Care System Joint Forward Plan, Annual Plan and Operational Plan submissions at a system level.
- Monitor the delivery of the Annual Plan, which sets out the NHS-led deliverables of the Joint Forward Plan, taking escalations from Provider Performance Meetings and agreeing a system response where necessary.
- be the formal route for change control of agreed Plans (for approval as appropriate by the respective governance bodies of each member).
- Oversee the allocation of system resource and ensure it is managed to deliver the greatest impact.
- review system performance and agree strategic responses to emerging performance risks.
- agree system level risks and issues and agree mitigating actions.
- horizon scan for emerging future challenges to agree on a system response to enable early intervention.
- review opportunities for greater system-wide working through the establishment of system-level delivery mechanisms.

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Section 8 – Primary medical services and other commissioning responsibilities delegated to NHS Devon

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8.1 Specialised Services

Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions. They deliver cutting-edge care and are a catalyst for innovation, supporting pioneering clinical practice in the NHS.

Specialised services are not available in every local hospital because they require specialist teams of doctors, nurses and other health professionals with the necessary skills and experience. Three factors determine whether a service is a prescribed specialised service. These are:

- the number of individuals who require the service
- the cost of providing the service or facility
- the number of people able to provide the service or facility

NHS England has delegated commissioning responsibility for 70 services to ICBs, whilst retaining accountability for this commissioning. NHS England continues to set consistent national standards, service specifications, and clinical commissioning policies; develop metrics and quality dashboards to support improvement, oversight, and assurance; and provide national clinical leadership, expert advice, and support to ICBs through their Clinical Reference Group infrastructure.

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Approximately 100 specialised services, including all highly specialised services, have not been delegated to ICBs and continue to be the direct commissioning responsibility and accountability of NHS England.

8.2 Primary Medical Services

Primary medical services provide the first point of contact in the healthcare system, acting as the ‘front door’ of the NHS.

In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England has delegated to NHS Devon the authority to commission the following range of services for the people of Devon:

- Primary medical services;
- Primary dental services and prescribed dental services;
- Primary ophthalmic services;
- Pharmaceutical services and local pharmaceutical services.

As a system, NHS Devon looks to primary care to lead on improving the ‘whole person’ health of a local population. Strengthening primary care and developing integrated neighbourhood teams is central to supporting NHS Devon’s fundamental shift from health care delivery focused on treating disease towards person-centred support for people facing the challenges of everyday life, in turn strengthening social cohesion and encouraging greater resilience.

This is primary care’s core role in an Integrated Care System - a shift from general practice as commissioners to general practice as providers, working through Primary Care Networks as vehicles for delivery, as stated in the NHS’s Long Term Plan and the five year framework for the GP contract, published in January 2019.

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8.3 List of providers of primary medical services (1 of 3 - Devon)

NHS Devon

• Abbey Surgery	• Clock Tower Surgery (Inclusion Health Devon)	• Moretonhampstead Health Centre	• Torrington Health Centre
• Amicus Health	• Coleridge Medical Centre	• Mount Pleasant Health Centre	• Townsend House Medical Centre
• Axminster Medical Practice	• College Surgery Partnership	• Northam Surgery	• Wallingbrook Health Centre
• Barnfield Hill Surgery	• Combe Coastal Practice	• Okehampton Medical Centre	• Westbank Practice
• Beacon Medical Group	• Cranbrook Medical Practice	• Pinhoe Surgery	• Whipton Surgery
• Bideford Medical Centre	• Foxhayes Practice	• Queens Medical Centre	• Wonford Green Surgery
• Blackdown Practice	• Fremington Medical Centre	• Redlands Primary Care	• Wooda Surgery
• Blake House Surgery	• Haldon House Surgery	• Rolle Medical Partnership	• Woodbury Surgery
• Bow Medical Practice	• Hartland Surgery	• Sampford Peverell Surgery	• Wyndham House Surgery
• Bradworthy Surgery	• Heavitree Practice	• Seaton & Colyton Medical Practice	• Yealm Medical Centre
• Bramblehaies Surgery	• Hill Barton Surgery	• Sid Valley Practice	• Yelverton Surgery
• Brannam Medical Centre	• Holsworthy Medical Centre (part of Ruby Country MG)	• South Lawn Medical Practice	• Torrington Health Centre
• Budleigh Salterton Medical Practice	• Honiton Surgery (Dr Ward and Partners)	• South Molton Medical Centre	• Townsend House Medical Centre
• Caen Medical Centre	• Ide Lane Surgery	• Southernhay House Surgery	• Wallingbrook Health Centre
• Castle Gardens Surgery	• Imperial Surgery	• St Leonards Practice	• Westbank Practice
• Castle Place Practice	• Isca Medical Practice	• St Thomas Medical Group	• Whipton Surgery
• Chagford Health Centre	• Litchdon Medical Centre	• Tavyside Health Centre	• Wonford Green Surgery
• Cheriton Bishop Surgery	• Mid Devon Medical Practice	• Topsham Surgery	• Wooda Surgery

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8.3 List of providers of primary medical services (2 of 3 - Plymouth)

• Adelaide Street Surgery	• Lisson Grove Medical Centre	• Stoke Surgery
• Budshead Medical Practice	• Mayflower Medical Group	• Wembury Surgery
• Church View Surgery	• North Road West Medical Centre	• West Hoe Surgery
• Dean Cross Surgery	• Oakside Surgery	• Wycliffe Surgery
• Devonport Health Centre	• Pathfields Surgery	• St Levan Surgery
• Elm Surgery	• Peverell Park Surgery	• St Neots Surgery
• Friary House Surgery	• Roborough Surgery	
• Knowle House Surgery	• Southway Surgery	

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8.3 List of providers of primary medical services (3 of 3 – Torbay)

• Albany Surgery	• Chilcote Surgery	• Leatside Surgery
• Ashburton Surgery	• Chillington Health Centre	• Mayfield Medical Centre
• Barton Surgery (Dawlish)	• Compass House Medical Centre	• Modbury Health Centre
• Bovey Tracey and Chudleigh Practice	• Corner Place Surgery	• Norton Brook Medical Centre
• Brunel Medical Practice	• Cricketfield Surgery	• Old Farm Surgery
• Buckfastleigh Medical Centre	• Croft Hall Medical Practice	• Pembroke House Surgery
• Buckland Surgery	• Dartmouth Medical Practice	• Redfern Health Centre
• Catherine House Surgery	• Devon Square Surgery	• South Brent Health Centre
• Channel View Medical Group	• Kingskerswell and Ipplepen Medical Practice	• Southover Medical Practice
• Chelston Hall Surgery	• Kingsteignton Medical Practice	• Leatside Surgery

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NHS Cornwall and Isles of Scilly

NHS Devon

Joint Policy on the Development & Management of Procedural Documents

NHS Devon
NHS Cornwall and Isles of Scilly

Document Reference	Policy on the Development & Management of Procedural Documents
Version	V1
Senior Responsible Officer	Company Secretary
Author/s	Head of Corporate Governance
Approved by	NHS Devon Integrated Care Board NHS Cornwall and Isles of Scilly Integrated Care Board
Date Approved	28 May 2026
Date Issued	1 June 2026
Date of next Review	31/03/2027

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Equality, diversity and inclusion statement

NHS Devon and NHS Cornwall and Isles of Scilly are committed to promoting equal opportunities, addressing health inequalities, and fostering good relations between people protected under the Equality Act 2010, the Health and Social Care Act 2012, and Human Rights legislation. We are equally committed to eliminating unlawful discrimination, harassment, and victimisation. To demonstrate this commitment, we develop, promote and maintain policies, strategies and operating procedures. Every effort is made to ensure that patients, employees, contractors or visitors do not experience discrimination; either directly or indirectly, because of their vulnerability; disadvantage; age, disability; gender reassignment; marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex (gender) or sexual orientation.

All staff must comply with this policy. Compliance must reflect our organisational commitment to and policy on equality, diversity and inclusion. In addition, each manager and member of staff involved in implementing this policy must give due regard to the needs of those protected under law.

If you, or any other groups, believe you are discriminated against under the terms of the Equality Act, the Health and Social Care Act 2012 or Human Rights legislation by anything contained in this document; or you need this document in an alternative format, for example, large print, Braille, Easy read or other languages; please contact our Patient Advice and Complaints Team (PACT):

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Policy Summary

Summary & Key Aims	Target Audience
This Policy sets out the process for developing and reviewing all procedural documents. The Policy aims to support staff in developing or reviewing documentation to determine whether it constitutes a Policy. Where there is a requirement to develop or review a Policy document, the key actions and approval pathway are set out in this Policy.	ALL staff who are involved in the writing, review, approval, implementation, and monitoring of procedural documentation on behalf of NHS Devon/ NHS Cornwall & Isles of Scilly ICBs. Members/groups who are responsible for approving procedural documents.
Key Requirements	**Previous Policy Names**
Formal consultation is required during the development of all strategic documents and certain policies. Relevant Impact Assessments must be completed for Policies. The staff partnership committee must consider all policies that affect employees' working lives.	This Policy supersedes the individual policies of NHS Cornwall and Isles of Scilly and NHS Devon of the same name.
Risks to the ICB if the policy isn't followed	**What could happen if staff don't follow the policy**
The key risks may include: Non-compliance with statutory and regulatory requirements, such as the Health and Care Act 2022. Increased exposure to risk if procedural documents are not properly ratified or monitored, as they can have corporate implications and pose risks to the ICB. Inconsistent or unclear governance, which may lead to confusion or gaps in accountability, especially if delegation of policy development is not clearly defined or followed.	The Author may experience delays in obtaining approval because procedural documents that do not comply with this policy will be returned to the Author for revision.

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1. Introduction

1.1. The effective management of policies and other procedural documents is a core component of good governance. This includes the development, approval, implementation, and review.

1.2. The effective control, management, review and monitoring of procedural documents contribute to the assurance of:

- Safe Operations
- Risk Reduction
- Staff awareness of current practice
- Good Governance
- Delivery of high-quality patient care
- Effective Quality Control
- Transparency for Stakeholders

1.3. The environment in which NHS Devon and NHS Cornwall and Isles of Scilly Integrated Care Boards (ICBs) operate is constantly changing, and the organisation must be able to respond to challenges from both external and internal sources.

2. Purpose

2.1. The purpose of this policy is to ensure a well-structured, systematic approach to the development, approval, implementation, review and monitoring of all procedural documents in use across NHS Devon and NHS Cornwall and Isles of Scilly.

2.2. This policy is designed to:

- Ensure that NHS Devon and NHS Cornwall and Isles of Scilly comply with the Health and Care Act 2022 and other relevant legislation and national standards in developing and reviewing its procedural documents.
- Outline the standards relating to content, structure, approval and monitoring of policies.
- Set out the requirements for the development and approval of all NHS Devon and NHS Cornwall and Isles of Scilly procedural documents.
- Establish the requirements for regular reporting and provision of assurance about the efficacy and effectiveness of the NHS Devon and NHS Cornwall and Isles of Scilly policy framework.

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3. Scope

3.1. This policy applies to all staff, including Board Members, involved in policy-making processes, whether permanent, temporary, or contracted for services (either as individuals or through third-party suppliers).

3.2. The scope of this policy includes the development, approval, implementation, review, publication and compliance monitoring of procedural documents.

4. Definitions

4.1. "*Procedural Documents*" is a collective term relating to any of the following documents in the hierarchy set out below:

Figure 1: Procedural Document Hierarchy

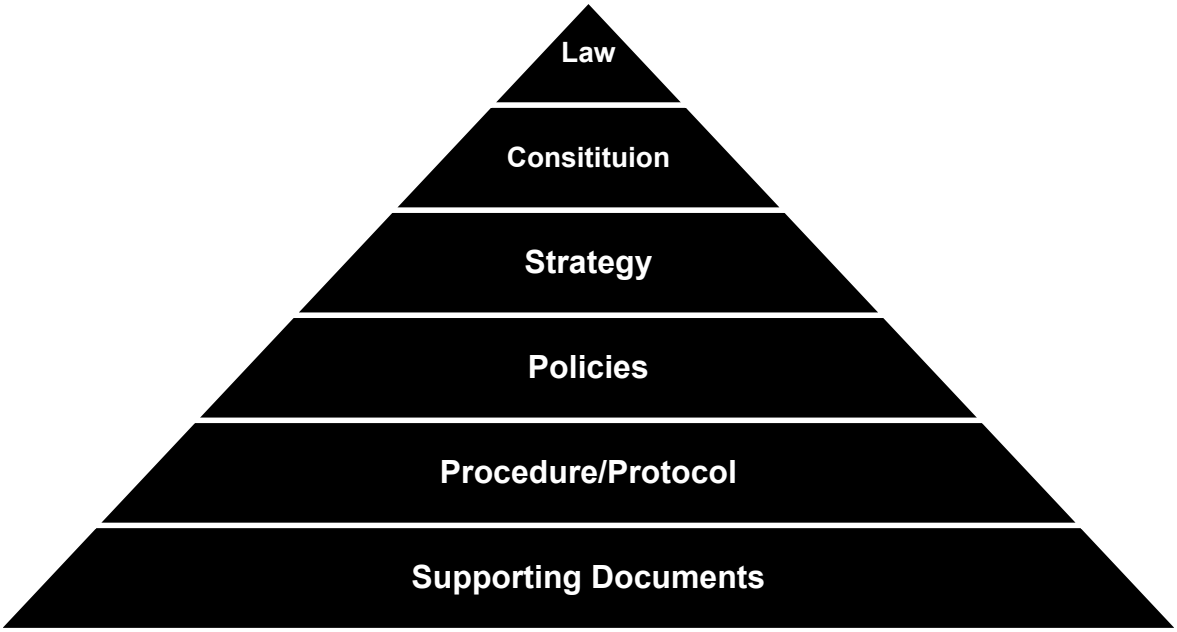

Table 1: Definitions

Terms	Definition
Law/ Regulations	Laws are created by an Act of Parliament or statute. The Health and Social Care Act 2006 and the Health and Care Act 2022 are the key statutes governing health and care in the UK. Regulations are secondary to statutes, as they are made under the authority granted by a statute. The Health and Social Care Act 2008

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Terms	Definition
	(Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009 are examples of regulations.
Constitution	The NHS Devon and NHS Cornwall and Isles of Scilly Constitutions outline how they will comply with their statutory duties under the Health and Care Act 2022 and associated regulations.
Strategy	A high-level, long-term plan of action, covering 3 to 5 years, to achieve a particular goal in relation to the strategic aims of the organisation. For example, a commissioning or financial strategy.
Policy	A policy is a statement that represents a definite course of action adopted by the ICB. Enabling consistently and effectively decision-making and actions, in line with relevant legislation, guidance and good practice.
Procedure/Protocol Standard Operating Procedure /	A procedure or protocol defines the mandatory steps required to achieve policy compliance. A Standard Operating Procedure (SOP) is an agreed set of instructions for performing a particular task.
Supporting Documents	Describes the steps that are taken by individual teams in support of relevant procedures. These steps may be used once or multiple times. This can include Guidelines, Forms, Handbooks, and Manuals that provide general advice while allowing for local discretion.

5. Developing a New Document

5.1. NHS Devon and NHS Cornwall and Isles of Scilly will identify the need to develop new procedural documents in line with the organisation's priorities, including national guidance, legislation, organisational changes, service requirements, and evidence-based practice, informed by the latest research, audit findings, national inquiries, and serious investigation reports.

5.2. The author should ensure that relevant expertise and advice are sought where necessary. Any proposals for a new procedural document should be discussed with the Corporate Governance team to determine whether a document already exists and which legislation, regulations, and standards apply. The Corporate Governance team will advise Authors on the requirements of this policy and on the relevant approval routes for proposed procedural documents (see section 8 below).

5.3. All policies must be compliant with current legal and statutory requirements that are relevant to their development. There must also be compliance with NHS policies/guidance, this policy and the NHS Devon and NHS Cornwall and Isles of Scilly standard policy template (including the standard style and format as outlined in the Standard Operating Procedure).

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6. Review and Refresh of Existing Documents

6.1. All approved strategies and policies will be published on the NHS Devon and NHS Cornwall and Isles of Scilly public website, intranet, or the internet. Any strategy or policy available on the intranet should be regarded as the current version and the one that NHS Devon and NHS Cornwall and Isles of Scilly adheres to, even if the review date has passed. An expired date does not automatically mean that the strategy or policy has been replaced.

6.2. Policy sponsors and Authors are responsible for maintaining and updating procedures/protocols and other supporting documents. These will not be included in the Policy Register maintained by the Corporate Governance team.

6.3. All procedural documents should be reviewed at least every three years or annually if required. However, a review may take place earlier if new evidence becomes available that necessitates it, e.g., changes in legislation or working practices.

6.4. The Corporate Governance team will take responsibility for contacting Authors and policy sponsors 3 months before their policies are due to become overdue to advise on the process and expected approval timelines.

6.5. If, when undertaken, a review indicates that only minor amendments are required, which will not alter current practice and, as such, involve no significant change to the document, the requirement to consult on a revised strategy or policy (see section 7) does not apply. Similarly, appendices can be reviewed, revised, or replaced at any time without requiring consultation, as outlined below.

6.6. Proposed minor updates to strategies or policies may proceed for approval via the relevant approval route (see section 8 below) once the relevant impact assessments and implementation plans have been completed.

6.7. If a review indicates significant changes to current practice and major amendments to the document are required, the procedures outlined in this policy apply and must be followed.

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6.8. If an author is unsure whether the proposed changes to a procedural document constitute a significant change to current practice, they should consult the Corporate Governance team for advice.

7. Consultation

7.1. Strategies outlined in section 3 and, where applicable, section 14Z45 of the NHS Act 2006, generally require consultation or engagement before approval. Some, like the joint forward plan, have specific legislative consultation rules (see 14Z54). A few policies also mandate formal consultation.

7.2. NHS Devon and NHS Cornwall and Isles of Scilly commit to full Staff Partnership consultation for their people-related policies, which should always involve the Staff Partnership Forum before approval.

7.3. Minor adjustments to strategies and policies don't need a consultation period, and approval isn't dependent on consulting protocols or supporting documents, though it's recommended.

8. Approval Process

8.1. Once any consultation is complete and any appropriate amendments have been made, the document may proceed to the approval stage. It is the responsibility of the author, or their nominated representative, to take a policy or similar document through to ratification, including seeking director endorsement where required.

8.2. In the absence of a designated Chief Officer to approve a policy, it may be approved by the nominated deputy during that period of absence. Policies can only be approved by the Chief Officers or, in their absence, their nominated deputy.

8.3. When submitting a policy or similar document for chief officer approval, authors should include all relevant, complete impact assessments, ensure they have carried out suitable consultation and provide a summary of the consultation responses received on the cover report.

Table 1: Sets out the formal part of the corporate governance process for the approval of procedural documents:

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Procedural Document	Review	Approval
Strategy/Long-term Plan	Executive endorsement before onward submission to the Board for ratification.	South West Peninsula Board
Policies	**New policies** – Relevant Chief Officer	South West Peninsula Executive Committee
	Existing high-risk or high-impact policies other than core corporate governance and finance policies - Relevant Chief Officer	South West Peninsula Executive Committee
	Remaining existing policies - Relevant Chief Officer, with the consultation of at least one other Chief Officer	Chief Officer
Procedure/protocol	N/A	Senior Leadership Team member with responsibility for the relevant policy area.
Report	N/A	All reports for Board Assurance Committee or Board meetings, as well as system-level meetings, shall be approved by the appropriate Chief Officer before submission for inclusion in agenda packs.
Guidelines (guidance notes)	Organisation-wide Team level	Chief Officer ratification Deputy director ratification

9. Accountabilities and Responsibilities

9.1. The following provides an overview of the duties of individuals and teams, including the levels of responsibility for developing policy and procedural documents.

The Board	is responsible for setting the strategic context for developing operational policies.
The Chief Executive	Has overall responsibility for the strategic and operational management of the ICB, including ensuring that the organisation's operational policies comply with all legal, statutory and good practice requirements.
Chief Officers	Act as policy sponsors and will determine if a new strategy, policy, or other approved document is required. They will support policies appropriate to their responsibilities and approve the strategy or policy ahead of submission for approval.

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Corporate Governance Team	Will maintain a Policy Register to prevent partial or complete duplication of any other approved strategy or policy in operation. Arranging for the relevant committee of the Board to be informed when an operational policy has been reviewed and updated. Ensuring obsolete versions of the ICB's operational policies are archived and retained for the life of the organisation.
Comms Team	Ensuring operational policies are uploaded to the staff intranet and/or the ICB website, where relevant. Including a list of newly developed and recently reviewed operational policies in the Staff Briefing email.
People Team	Are responsible for ensuring appropriate consultation with staff-side representatives for all Human Resources policies.
Line Managers	Ensure they know and understand all those policies and procedural documents relevant to their roles. Ensure all their staff comply with relevant policies and procedures and take corrective action for non-compliance in accordance with the ICB's capability and disciplinary policies.
All Staff	Ensure they know and understand all those policies and procedural documents relevant to their roles. All individuals must adhere to applicable policies and procedures. If non-compliance occurs, line managers may take corrective action as necessary, in line with the ICB's capability and disciplinary policies.

10. Impact assessments

10.1. The Equality Act 2010 includes a general legal duty to:

- Eliminate unlawful discrimination, harassment, victimisation and any other
- conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected
- characteristic and people who do not share it.
- Foster good relations between people who share a protected characteristic
- and people who do not share it.

10.2. NHS Devon and NHS Cornwall and Isles of Scilly must demonstrate due regard to the general duty. This means active consideration of equality must influence the decision/s reached that will impact on patients, carers, communities and staff.

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10.3. An Equality Impact Assessment (EIA) and a Quality Impact Assessment (QIA) should be completed for every policy and in accordance with the ICB's

EIA and QIA toolkits. The EIA is a way of systematically analysing a new or changing policy, strategy, process, etc. to identify what effect, or likely effect, it could have on 'protected groups'. Potential adverse impacts on any protected group identified through the EIA/QIA will be monitored as part of routine compliance monitoring.

10.4. The General Data Protection Regulation (GDPR) / Data Protection Act 2018 require a Data Protection Impact Assessment for any processing likely to result in a high risk to individuals.

10.5. Consideration should be given to any impact the policy may have on individual privacy; please consult the Data Protection Officer.

10.6. All completed impact assessments must be shared with the Chief Officer for sign-off on the procedural document before seeking final approval. Procedural documents without an EIA or a QIA will not be accepted for recommendation/approval.

11. Accessibility Standards

11.1. NHS Devon and NHS Cornwall and Isles of Scilly expect documents to meet the relevant accessibility standards in force at the time of ratification. These standards ensure that we meet our obligations to make content and design clear and simple. This means as many people as possible can use it.

12. Implementation

12.1. All policies and procedures are accessible online through the NHS Devon and NHS Cornwall and Isles of Scilly intranet and/or public website. Newly uploaded policies and procedures are highlighted in the latest documents section on the intranet to inform and guide staff to their publication and availability.

12.2. All staff will be notified of the policy's approval through the Staff Bulletin, which will include a link to the document on the NHS Devon and NHS Cornwall and Isles of Scilly Intranet.

12.3. Departmental managers, team leaders, and professional leads are responsible for ensuring that a system is in place within their respective areas to ensure their staff are aware of, have read, and understand relevant new and revised policies.

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13. Monitoring compliance and effectiveness

13.1. Each procedural document must set out suitable arrangements for monitoring compliance with its requirements.

13.2. Procedural documents that are not policies or ICB-wide will be maintained and managed by their Author/team. It is the Authors' and teams' responsibility to ensure documents are kept up to date. Where practicable, the Corporate Governance team may conduct periodic audits of the document library and issue reminders to authors of out-of-date procedural documents.

13.3. The Corporate Governance team will provide the NHS Devon and NHS Cornwall and Isles of Scilly Audit and Risk Committees meeting in common with a quarterly report detailing all new policies and procedures that have been ratified and uploaded to the intranet, as well as any overdue documents and those due for review in the next quarter.

13.4. Internal Audit may be commissioned to undertake periodic reviews of procedural documents, other than policies, to test their compliance. All procedural documents that operate in NHS Devon and NHS Cornwall and Isles of Scilly may be in scope for compliance and assurance testing and reporting by the internal audit teams. The Audit and Risk Committees meeting in common will consider the findings from any audits.

14. Approval and Review

14.1. The approval route for the Policy will be via the NHS Devon and NHS Cornwall and Isles of Scilly Integrated Care Boards.

14.2. This policy will be reviewed every year, or more frequently if required, to ensure it remains current and relevant, and reflects the strategic aims, objectives, organisational structures, and responsibilities of NHS Devon and NHS Cornwall and Isles of Scilly.

15. References

15.1. This Policy doesn’t sit in isolation and should be read in conjunction with the following:

- The Standard Operating Procedure for the Development and Management of Procedural Documents
- Freedom of Information Policy

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- Equality and Diversity Policy
- Accessibility Policy

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NHS Cornwall and Isles of Scilly

NHS Devon

Joint Policy on Standards of Business Conduct

NHS Devon
NHS Cornwall and Isles of Scilly

Document Reference	Policy on Standards of Business Conduct
Version	V1
Senior Responsible Officer	Company Secretary
Author/s	Head of Corporate Governance
Approved by	NHS Devon Integrated Care Board, NHS Cornwall and Isles of Scilly Integrated Care Board
Date Approved	28 May 2026
Date Issued	1 June 2026
Date of next Review	31/03/2027

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Equality, diversity and inclusion statement

NHS Devon and NHS Cornwall and Isles of Scilly are committed to promoting equal opportunities, addressing health inequalities, and fostering good relations between people protected under the Equality Act 2010, the Health and Social Care Act 2012, and Human Rights legislation. We are equally committed to eliminating unlawful discrimination, harassment, and victimisation. To demonstrate this commitment, we develop, promote and maintain policies, strategies and operating procedures. Every effort is made to ensure that patients, employees, contractors or visitors do not experience discrimination; either directly or indirectly, because of their vulnerability; disadvantage; age, disability; gender reassignment; marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex (gender) or sexual orientation.

All staff must comply with this policy. Compliance must reflect our organisational commitment to and policy on equality, diversity and inclusion. In addition, each manager and member of staff involved in implementing this policy must give due regard to the needs of those protected under law.

If you, or any other groups, believe you are discriminated against under the terms of the Equality Act, the Health and Social Care Act 2012 or Human Rights legislation by anything contained in this document; or you need this document in an alternative format, for example, large print, Braille, Easy read or other languages; please contact our Patient Advice and Complaints Team (PACT):

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Policy Summary

Summary & Key Aims	Target Audience
Aim: Ensure all employees conduct business with honesty, integrity, and transparency. This is critical to maintaining public trust and protecting the ICB and its decision-making processes from impropriety. **Purpose:** Set clear expectations for responsible, ethical, and professional behaviour across all ICB activities.	All staff (including interim and temporary staff, contractors and seconded staff) have a duty to comply with this Policy.
Key Requirements	**Previous Policy Names**
Act with integrity, be impartial and honest in all your business activities. Don't use your position for personal advantage or seek to gain preferential treatment. Declare any actual or potential interests which may be perceived as a conflict of interest. Respect and promote the corporate or collective decision of NHS Devon or NHS Cornwall and Isles of Scilly, irrespective of your own views. If you are uncertain, ask before you act. Speak with your line manager in the first instance. This policy should be read alongside those related policies described in Section 11.	Policy supersedes the individual policies of NHS Cornwall and Isles of Scilly and NHS Devon of the same name.
Risks to the ICB if the policy isn't followed	**What could happen if staff don't follow the policy**
Failing to follow this policy may expose the ICBs to significant risks, including: • **Financial losses, security breaches, and reputational damage** due to policy negligence. • **Legal and regulatory consequences**, such as civil challenges or criminal offences (e.g., fraud, bribery, or corruption), especially if conflicts of interest are not managed properly.	Staff who don't follow this policy may be found in breach of it and may face investigation and appropriate action, including disciplinary action or referral to an external agency, in line with the ICB's disciplinary and ICB policies.

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• **Erosion of public trust** and potential breaches of legal obligations under the NHS Act 2006, which could undermine the ICB's compliance and operational integrity. • **Inhibited decision-making** and actions that may not align with the ICB's best interests, particularly if conflicts of interest are not addressed transparently.	

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1. Introduction

1.1. It is a long and well-established principle that public-sector organisations must be impartial and honest in their business and that their officers must act with integrity. As publicly funded organisations, NHS Devon and NHS Cornwall and the Isles of Scilly aspire to the highest standards of corporate behaviour and responsibility.

1.2. The NHS Constitution sets out some of the key responsibilities of NHS staff. All officers, regardless of their role, are expected to act in the spirit set out in the seven principles of public life; the 'Nolan Principles' (outlined in Appendix 1).

1.3. This policy describes the standards and values which underpin the work of NHS Devon and NHS Cornwall and Isles of Scilly and reflects current guidance and best practice, which all Board Members, staff and decision-making groups should follow.

2. Purpose

2.1. This policy seeks to describe the public service values, which underpin the work of the NHS and to reflect the current guidance and best practice to which all individuals within NHS Devon and NHS Cornwall and Isles of Scilly Integrated Care Boards (ICBs) must have regard when undertaking their role.

2.2. This policy will:

- Set out a clear framework of the expected high standards of corporate behaviour and responsibility from NHS Devon and NHS Cornwall and Isles of Scilly Board Members, staff and decision-making groups;
- Support staff in ensuring that NHS Devon and NHS Cornwall and Isles of Scilly are impartial and honest in its business and that its staff act with integrity; and
- Protect NHS Devon and NHS Cornwall and Isles of Scilly from any suggestion of corruption, partiality or dishonesty by providing a clear framework through which the organisation can provide guidance and assurance that its decision-makers conduct themselves appropriately.

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2.3. This policy is supported by the Declaration of Interest, including Gifts, Hospitality and Sponsorship Standard Operating Procedure owned by the Corporate Governance team.

3. Scope

3.1. This policy applies to all staff, including Board Members, involved in policy-making processes, whether permanent, temporary, or contracted for services (either as individuals or through third-party suppliers).

4. Definitions

Terms	Definition
Third party	In this policy, "third party" refers to any individual or organisation that officers may come into contact with during the course of their work for NHS Devon or NHS Cornwall and Isles of Scilly, and includes actual and potential clients, suppliers, distributors, business contacts, agents, advisers, and government and public bodies, including their advisors, representatives and officials, politicians and political parties.
Joint Working	Joint working is defined as situations where, for the benefit of patients, organisations pool skills, experience and/or resources for the joint development and implementation of patient centred projects and share a commitment to successful delivery. Joint working agreements and management arrangements are conducted in an open and transparent manner.
Commercial sponsorship	Commercial sponsorship is defined as including: NHS funding from an external source, including funding of all or part of the costs of an officer, NHS research, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (speakers), buildings or premises.
Industry	Commercial and non-commercial organisations (including patient groups) external to NHS Devon or NHS Cornwall and Isles of Scilly.
Officer	An individual who is directly or not directly employed by NHS Devon or NHS Cornwall and Isles of Scilly but is involved in the delivery of their work.

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5. Managing Standards of Business Conduct

Conflicts and Declarations of Interest

5.1. Officers are expected to act at all times with the utmost integrity and objectivity and in the best interests of the organisation in performing their duties, and to avoid situations where there may be a potential conflict of interest. Officers must not use their position for personal advantage or seek to gain preferential treatment. Any actual or potential interests which may be perceived as conflicting with that overriding requirement must be declared.

5.2. Further information about what constitutes a conflict of interest and how these should be managed can be found in the NHS Devon and NHS Cornwall and Isles of Scilly Joint Policy on Conflicts of Interest. The Joint Policy on Conflicts of Interest also addresses the management of the following:

- Managing Conflicts of Interest at meetings
- Managing Conflicts of Interest in the procurement process
- Gifts and Hospitality
- Meals and Refreshments
- Travel and Accommodation
- Outside employment
- Patents

5.3. Registers of these interests are maintained by the Corporate Governance team, who will formally record the declared interests of all decision-making officers. They will retain a record of historic interests for a minimum of six years after the date on which the interest expired. There may be occasions when an officer declares an interest that the Corporate Governance team later deems immaterial. In such an instance, the declaration will be recorded but not published.

Working with Industry and Sponsorship

5.4. The Department of Health and Social Care recognises that joint working with the pharmaceutical industry or other third-party organisations, where the benefits to patient care and the difference it could make to their health and wellbeing are clearly advantageous, should be considered by NHS organisations and their employees.

5.5. *Commercial Sponsorship - Ethical Standards in the NHS* requires local arrangements to be developed in relation to commercial sponsorship within a

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national framework. This document recognises that there can be mutual benefit in partnership arrangements with organisations external to the NHS, but only if they are agreed within a framework with the necessary safeguards and checks.

5.6. Positively engaging with companies and practices may lead to larger, longer term collaborations that meet the needs of all parties; however; the benefits of greater collaboration must be weighed against any potential risks and it is essential therefore that all projects are subject to the widest scrutiny; that the business priorities of commercial organisations do not lead to a distortion of local priorities or investment; and that any such arrangements are fully transparent and deliver maximum benefits for patients and the health economy.

5.7. The principles underpinning sponsorship and joint working are in Appendix 2

5.8. Potential joint working arrangements and sponsorship will be considered through a process for consideration, approval, recording, monitoring and evaluation. Officers who wish to pursue joint working or sponsorship initiatives are advised to follow the process outlined in the Working with Industry and Sponsorship Guidance and send the completed application form to the relevant Chief Officer for a decision.

5.9. One of the main ways in which officers may interact with industry is when an organisation sponsors an event or meeting, provides training or educational materials, offers gifts or hospitality, or offers to support other costs and equipment. The way in which such offers should be considered is set out in the Joint Policy on Conflicts of Interest. However, as a general rule:

- Attendance at an event or conference sponsored / hosted by an external organisation, e.g. clarify with the sponsor and record the sponsor's expectation from providing the sponsorship concerning attendance. If there are no known expectations from the sponsor, the attendance can be acceptable, but it must be agreed by a line manager in advance, and a declaration form completed.

- Offers of individual funding to allow officers to attend educational courses / obtain professional qualification - the offer should be declined and recorded on the declaration form.

5.10. All offers of sponsorship, funding or gifts from pharmaceutical companies must comply with the current ABPI Code of Practice

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Fraud, Bribery and Corruption

5.11. Under the Bribery Act (2010), it is a criminal offence for an employee to:

- offer, promise or give a bribe;
- request, agree to receive or accept a bribe; and
- make a representation that is false for personal or other gain or that puts NHS Devon or NHS Cornwall and Isles of Scilly at risk of loss.

5.12. It is also a criminal offence for NHS Devon or NHS Cornwall and Isles of Scilly to fail to prevent bribery.

5.13. Bribery can be money, gifts, hospitality or anything else that may be of benefit to the person, which in turn creates a conflict between his/her own interests and the interests of those that he/she is expecting to be serving.

5.14. The Bribery Act (2010) also covers individuals who have an association with an organisation - an 'associated person'. This term is not just limited to Board Members and Officers, but any person, company or legal entity that carries out a service under the ICB's name, represents the ICB in an official capacity, acts on behalf of the ICB or in the place of NHS Devon or NHS Cornwall and Isles of Scilly. The maximum penalty for bribery is 10 years imprisonment for individuals engaging in bribery and an unlimited fine for NHS Devon or NHS Cornwall and Isles of Scilly.

5.15. The Economic Crime and Corporate Transparency Act 2023 introduced the failure to prevent fraud offence, which came into force on 1 September 2025. The offence is intended to hold large organisations (NHS organisations are in scope) into account if they profit from fraud. In the event of prosecution, the ICB would have to demonstrate to the court that it had reasonable fraud prevention measures in place at the time the fraud was committed.

5.16. Both NHS Devon and NHS Cornwall and Isles of Scilly are committed to preventing fraud and encourages officers with concerns or reasonably held suspicions about potentially fraudulent activity or practice, to report these. Officers must inform the Chief Finance Officer or the Local Counter Fraud Specialist (LCFS), whose details can be found on the NHS Devon and NHS Cornwall and Isles of Scilly intranet.

5.17. Concerns can be raised anonymously by contacting the NHS Reporting Line on 0800 028 40 60 or via www.reportnhsfraud.nhs.uk. Officers must not ignore any suspicion and must not, under any circumstances, investigate the matter themselves or inform colleagues or members of the public of their suspicions.

Commented [KH1]: As has been done for the Bribery Act above, some fraud legislation to start this paragraph would be useful. Suggest: The Economic Crime and Corporate Transparency Act 2023 introduced the failure to prevent fraud offence which came into force 1 September 2025. The offence is intended to hold large organisations (NHS organisations are in scope) into account if they profit from fraud. In the event of prosecution, the ICB would have to demonstrate to the court that it had reasonable fraud prevention measures in place at the time the fraud was committed.

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Charitable Collections

Individual

5.18. Whilst NHS Devon and NHS Cornwall and Isles of Scilly support Officers who wish to undertake charitable collections amongst immediate colleagues, no reference or implication should be drawn to suggest that either ICB is supporting the charity.

5.19. Collection tins or boxes must not be placed in offices. With line management agreement, collections may be made among immediate colleagues and friends to support small fundraising initiatives, such as raffle tickets and sponsored events.

5.20. Permission is not required for informal collections amongst immediate colleagues on an occasion like retirement, marriage, birthday or a new job.

Organisational

5.21. Charitable collections which reference either NHS Devon or NHS Cornwall and Isles of Scilly must be authorised and documented by the appropriate Chief Officer in advance and reported to the Corporate Governance team, who will keep an internal record.

Political Activities

5.22. Any political activity should not identify an individual as an Officer of either NHS Devon or NHS Cornwall and Isles of Scilly. Conferences or functions run by a party-political organisation should not be attended in an official capacity, except with prior written permission from the relevant Chief Officer. The ICBs recognise that colleagues from local authorities who serve on our Boards, Committees, or Subcommittees may not be able to meet this expectation.

Personal Conduct

Corporate Responsibility

5.23. All officers have a responsibility to respect and promote the corporate or collective decision of NHS Devon or NHS Cornwall and Isles of Scilly, even though this may conflict with their personal views. This applies particularly if the ICBs are yet to decide on an issue or has decided in a way with which they personally disagree. Directors and officers may comment as they wish as individuals. However, if they decide to do so, they should make it clear that they are expressing their personal view and not the view of either ICB.

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5.24. When speaking as a member of NHS Devon and NHS Cornwall and Isles of Scilly, whether to the media, in a public forum or in a private or informal discussion, officers should ensure that they reflect the current policies or views of the organisation. For any public forum or media interview, approval should be sought in advance.

5.25. All officers must ensure their comments are well considered, sensible, well-informed, made in good faith, in the public interest and without malice and that they enhance the reputation and status of NHS Devon or NHS Cornwall and Isles of Scilly.

5.26. Officers must follow the guidance for communication with the media; disciplinary action may be taken if this is not followed.

Use of Social Media

5.27. Officers should be aware that social networking websites are public forums and should not assume that their entries will remain private.

5.28. Officers must not conduct themselves in a way that brings either NHS Devon or NHS Cornwall and Isles of Scilly into disrepute or disclose information that is confidential to ICB business, officers or patients.

Confidentiality

5.29. Officers must operate in accordance with the Data Protection Act 2018 and UK General Data Protection Regulations, and maintain the confidentiality of information of any type, including but not restricted to patient information; personal information relating to officers; or commercial information.

5.30. This duty of confidence remains after officers (however employed) leave NHS Devon and NHS Cornwall and Isles of Scilly.

5.31. For the avoidance of doubt, this does not prevent the disclosure or information where there is a lawful basis for doing so (e.g. consent). Officers should refer to the suite of ICB Information Governance policies for detailed information.

Lending or Borrowing

5.32. The lending or borrowing of money between officers is not permitted, whether informally or as a business.

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5.33. It is a particularly serious breach of the NHS Devon and NHS Cornwall and Isles of Scilly Disciplinary Policies for any officer to use their position to place pressure on someone in a lower pay band, a business contract, or a member of the public to loan them money.

Gambling

5.34. No officer may bet or gamble when on duty or on NHS Devon or NHS Cornwall and Isles of Scilly premises, apart from small lottery syndicates or sweepstakes related to national events such as the World Cup or Grand National among immediate colleagues where no profits are made or the lottery is wholly for purposes that are not for private or commercial gain (e.g. to raise funds to support a charity see above).

Trading on Official Premises

5.35. Trading on official premises is prohibited, whether for personal gain or on behalf of others. This includes but is not limited to flyers advertising services and/ or products in shared areas and catalogues in shared areas.

5.36. Canvassing within the office by, or on behalf of, outside bodies or firms (including non-ICB interests of officers or their relatives) is also prohibited.

5.37. Trading does not include small tea or refreshment arrangements solely for officers.

Individual Voluntary Arrangements, County Court Judgment, Bankruptcy / Insolvency

5.38. Any officer who becomes bankrupt, insolvent, has an active County Court Judgment, or made individual voluntary arrangements with organisations must inform their line manager and the HR team as soon as possible. Officers who are bankrupt or insolvent cannot be employed, or otherwise engaged, in posts that involve duties which might permit the misappropriation of public funds or involve the approval of orders or handling of money.

Arrest or Conviction

5.39. An officer who is arrested, subject to continuing criminal proceedings, or convicted of any criminal offence must inform their line manager and the HR team as soon as is practicably possible. Cautions, penalty charge notices, and fixed penalty notices are not considered to be criminal convictions.

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PREVENT

5.40. Any officer who has concerns regarding the possibility of a potential link to extremism or radicalisation in relation to the areas covered by this policy should refer to the ICB PREVENT Policy which provides guidance on how to seek advice.

Publication

5.41. Declarations made in accordance with this policy by decision making officers will be published on the NHS Devon and NHS Cornwall and Isles of Scilly website. The Corporate Governance team will make available the registers of all officer declarations on request.

5.42. In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an individual's name and/or other information may be redacted from the publicly available register(s). Where an officer believes that substantial damage or distress may be caused to him/herself or somebody else by the publication of information about them, they are entitled to request that the information is not published. Such a request must be made in writing to the Corporate Governance team, who will seek legal advice where required. All requests for non-publication will be considered by the Conflicts of Interest Guardian and the Company Secretary. Non-publication of interests would only be agreed as the exception and information will not be withheld or redacted merely because of a personal preference. A confidential, un-redacted version of the register will be held securely by the Corporate Governance team.

5.43. Officers should be aware that external organisations, e.g. Association of British Pharmaceutical Industries (ABPI), may also publish information relating to commercial sponsorship or other payments. The Corporate Governance team will review such publications to ensure that appropriate internal declarations have been made in accordance with this policy and will take appropriate action where they have not.

5.44. Anonymised information relating to breaches and how those breaches have been managed will be published on the website quarterly and retained for a year.

Raising a Concern or Reporting a Breach

5.45. There may be occasions when breaches have not been identified, declared or managed appropriately and effectively. This may occur accidentally or through deliberate action. Officers should speak up about any genuine concerns in relation to compliance with this policy. These concerns can be

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raised directly with the officer's line manager, or alternatively with the Company Secretary, the Chief Finance Officer, or the Conflicts of Interest Guardian.

5.46. All reported concerns will be treated with the appropriate confidentiality and investigated in line with NHS Devon's policies and procedures.

5.47. Significant breaches should be reported to the Audit and Risk Committees meeting in common as soon as practicably possible, together with the action being taken to address it.

5.48. Officers must report any suspicions of fraud, bribery and corruption as soon as they become aware of them to the Counter Fraud Team to ensure that they are investigated appropriately and to maximise the chances of financial recovery.

5.49. Officers may also wish to report concerns via the Freedom to Speak Up Guardian.

Failure to comply with the Standards of Business Conduct Policy

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

5.51. Where the failure to comply relates to an officer that is not a direct employee of NHS Devon and NHS Cornwall and Isles of Scilly, this may result in action being taken in accordance with the relevant engagement procedures (e.g. termination of a secondment agreement).

5.52. Any financial or other irregularities or impropriety which involve evidence or suspicion of fraud, bribery or corruption by any officer, will be reported to the Counter Fraud team in accordance with Standing Financial Instructions 1and the Fraud, Bribery and Corruption policy2, with a view to an appropriate investigation being conducted and potential prosecution being sought.

[1] Standing Financial Instructions
[2] Fraud, Bribery and Corruption Policy

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6. Accountabilities and Responsibilities

Chief Executive Officer	The Chief Executive Officer has ultimate accountability for the strategic direction and operational management of NHS Devon, including compliance with all legal, statutory and policy requirements.
Company Secretary	is responsible for (in conjunction with the Conflicts of Interest Guardian: • Considering any requests for non-publication of interests. • Following any investigation into a potential breach: o Deciding if there has been or is potential for a breach and if so what the severity of the breach is. o Assessing whether further action is required in response; this is likely to involve any officer involved and their line manager, as a minimum. o Considering who else inside and outside the organisation should be made aware. o Taking appropriate action.
Conflicts of Interest (CoI) Guardian	This role is undertaken by a Non-Executive Member of the Board and further strengthens scrutiny and transparency of NHS Devon's decision-making processes. The CoI Guardian is supported by the Company Secretary to: • Act as a conduit for officers, members of the public and healthcare professionals who have any concerns regarding CoI. • Be a safe point of contact for officers to raise concerns in relation to this policy. • Support the rigorous application of CoI principles and policies. • Provide independent advice and judgement to officers where there is any doubt about how to apply CoI policies and principles. • Provide advice on minimising the risks of CoI. In conjunction with the Company Secretary the Guardian is also responsible for considering any requests for non-publication of interests and actions following any investigation into a possible breach.

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Audit & Risk Committee	Reports in relation to conflicts of interest and standards of business conduct (including Gifts and Hospitality, and Sponsorship and Joint Working) will be received by NHS Devon's Audit and Risk Committee for assurance.
NHS Devon Executive	Reports in respect of compliance with the Standards of Business Conduct policy, together with any breaches and the impact of those breaches to ensure learning and improvement.
Working with Industry & Sponsorship Group	Reviews applications for sponsorship and joint working agreements (making recommendations to ICB Executives) and monitors compliance with this policy.
Corporate Governance team	Ensuring that the Standards of Business Conduct Policy is implemented by teams across the ICB and that compliance is monitored and reported.
Line Managers	Line managers have a responsibility to ensure that ▪ All staff are notified of the policy, with new staff informed of this policy as part of their induction. ▪ All their staff comply with the on policies and standards within their areas of responsibility, including Standing Financial Instructions.
All Staff/Officers	Employed or engaged staff have a duty to comply with the policies and standards, including Standing Financial Instructions, as outlined in their contracts of employment and codes of conduct.

7. Impact assessments

7.1. An Equality Quality Impact Assessment (EQIA) has been completed in respect of this policy. No concerns were highlighted.

8. Implementation

8.1. Staff will be informed of the approval of the Policy via the Staff Bulletin, which will provide a link to the document on the Intranet.

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8.2. Training on conflicts of interest forms part of the mandatory annual training programme for all staff and is delivered through online modules accessible via the Electronic Staff Record.

8.3. In addition to the mandatory training, the Corporate Governance team will provide awareness sessions to staff via Staff Briefings and articles in the Staff Bulletin.

8.4. This policy is subject to approval of the NHS Devon and NHS Cornwall and Isles of Scilly Integrated Care Boards following recommendation from the Audit & Risk Committees meeting in common.

9. Monitoring Compliance and Effectiveness

9.1. The Chief Executive Officer will review compliance and effectiveness of the Standards of Business as part of the Annual Report process.

9.2. Compliance with this policy will be monitored by the Corporate Governance team, who will report to the Audit & Risk Committees meeting in common bi - annually in respect of compliance, together with any breaches and the impact of these breaches, to ensure learning and improvement.

9.3. Any trends resulting from non-compliance will be raised with officers through management routes.

10. Review

10.1. This policy will be reviewed annually or sooner in the event of changes to legislation, national guidance or the local context.

11. References

11.1. This policy should be considered alongside the following related policies mentioned in this document.

- Counter Fraud, Bribery and Corruption Policy
- Freedom to Speak Up Policy
- Joint Policy on Managing Conflicts of Interest
- Procurement Policy for all ICB Expenditure
- Standing Financial Instructions
- Scheme of Reservation and Delegation.

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APPENDIX 1 – Nolan Principles

1. Selflessness
   Holders of public office should act solely in terms of the public interest. They should not do so to gain financial or other benefits for themselves, their family or their friends.

2. Integrity
   Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

3. Objectivity
   In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

4. Accountability
   Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

5. Openness
   Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

6. Honesty
   Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

7. Leadership
   Holders of public office should promote and support these principles by leadership and example.

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APPENDIX 2 – Principles of Sponsorship and Joint Working

Working in the interests of patients to deliver high-quality care

- Joint projects between the ICBs and industry must be for the benefit of their populations
- Any joint project must adequately respect and safeguard confidential patient information in line with ICB policy on confidentiality and the Data Protection Act 2018, incorporating the UK General Data Protection Regulations.
- Joint working between the ICBs and industry must promote evidence-based medicine and support only those drugs and treatments that have acceptable evidence base and which have local formulary approval where applicable.

Supporting the delivery of the ICBs' strategic objectives and local needs

- The ICBs will take a whole-systems approach to joint working. This will ensure that only arrangements that benefit the whole NHS are approved. Arrangement which would lead to higher costs or a reduction in quality in other areas of the NHS or shift the balance of investment in service in a manner not consistent with local priorities, are not acceptable.
- The ICBs will not undertake joint working or accept sponsorship from industry to support projects that are contrary to their strategic priorities
- The continuity of any services funded through sponsorship or joint working must be fully considered before entering into any arrangements.

Selection and approval of sponsorship and joint working partners

- Where sponsorship or joint working is being sought by the ICBs, the opportunity to participate should be offered to an appropriate range of companies within the pharmaceutical industry
- All joint working or sponsorship must be assessed and declared.
- The ICBs may pursue joint working with any interested company of good standing regardless of its size.
- No preferential access to the ICBs is to be given to any commercial company unless this is necessary as part of a specific ICB approved project.

Transparency and openness

- All relationships with industry must be handled in an open and transparent manner as befits publicly funded bodies
- Joint working or sponsorship will not be accepted for projects that have the prime objective of increasing the usage of a specific brand of pharmaceutical or other product

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- Collaborative working arrangements should take place at a corporate, rather than an individual, level

Relationship between NHS Devon and NHS Cornwall & Isles of Scilly and industry

- The ICBs seek to develop long term relationships with industry and will look favourably on undertaking joint projects with companies that have a proven history of ethical and productive joint working
- The ICBs will preferentially support sponsorship and joint working that develops the expertise and capabilities of the employees and organisations within the health and social care community to provide high quality care for their populations
- All joint working projects and associated materials must comply with the current Association of the British Pharmaceutical Industry (ABPI) code of practice, whether or not the company is a member of the ABPI
- Any learning or products (such as protocols, guidelines, intellectual property) developed through joint working will be the property of the ICBs unless specifically agreed otherwise in a signed contract with the company(ies) and may be shared with other NHS organisations.
- The ICBs will consider supporting the dissemination of lessons learned from joint working but retain the right of approval of associated literature and material.

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APPENDIX 3 – External references

Legislation and statutory requirements

- Bribery Act 2010:
- Equality Act 2010:
- Fraud Act 2006:
- Freedom of Information Act 2000
- Health and Care Act 2022:
- Medicines (Monitoring of Advertising) Regulations 1994: https://www.legislation.gov.uk/uksi/1994/1933/made
- The Money Laundering Regulations 2007: The Money Laundering Regulations 2007 (legislation.gov.uk)
- National Health Service Act 2006: National Health Service Act 2006 (legislation.gov.uk)
- Procurement Policy and Regulation Proceeds of Crime Act 2002:
- NHS England: Managing Conflicts of Interest: Statutory Guidance:

Best practice recommendations and other key guidance

- NHS England - Standards of Business Conduct for NHS Staff:
- NHS England Guidance on Appearance of Bias:
- Commercial Sponsorship – Ethical Standards for the NHS:
- Association of the British Pharmaceutical (ABPI) Code of Practice:
- Department of Health - Confidentiality: NHS Code of Practice:
- General Medical Council (GMC) : Good Medical Practice
- Good Governance Standards of Public Services:
- Department of Health. Best Practice Guidance on joint working between the NHS and pharmaceutical industry and other relevant commercial organisations 2008.

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Joint Policy for the Management of Conflicts of Interest

NHS Devon
NHS Cornwall and Isles of Scilly

Document Reference	**Policy for the Management of Conflicts of Interest**
Version	V1
Senior Responsible Officer	Company Secretary
Author/s	Head of Corporate Governance
Approved by	NHS Devon Integrated Care Board NHS Cornwall and Isles of Scilly Integrated Care Board
Date Approved	28 May 2026
Date Issued	1 June 2026
Date of next Review	31/03/2027

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Equality, diversity and inclusion statement

NHS Devon and NHS Cornwall and Isles of Scilly are committed to promoting equal opportunities, addressing health inequalities, and fostering good relations between people protected under the Equality Act 2010, the Health and Social Care Act 2012, and Human Rights legislation. We are equally committed to eliminating unlawful discrimination, harassment, and victimisation. To demonstrate this commitment, we develop, promote and maintain policies, strategies and operating procedures. Every effort is made to ensure that patients, employees, contractors or visitors do not experience discrimination; either directly or indirectly, because of their vulnerability; disadvantage; age, disability; gender reassignment; marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex (gender) or sexual orientation.

All staff must comply with this policy. Compliance must reflect our organisational commitment to and policy on equality, diversity and inclusion. In addition, each manager and member of staff involved in implementing this policy must give due regard to the needs of those protected under law.

If you, or any other groups, believe you are discriminated against under the terms of the Equality Act, the Health and Social Care Act 2012 or Human Rights legislation by anything contained in this document; or you need this document in an alternative format, for example, large print, Braille, Easy read or other languages; please contact our Patient Advice and Complaints Team (PACT):

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Policy Summary

Summary & Key Aims	Target Audience
Aim: Clarify acceptable and unacceptable behaviours for staff to ensure transparency and accountability. **Purpose**: Provide consistent principles and rules to support NHS Devon, NHS Cornwall, and the Isles of Scilly in managing conflicts of interest effectively.	All staff (including interim and temporary staff, contractors and seconded staff) have a duty to comply with this Policy.
Key Requirements	**Previous Policy Names**
Disclose all interests where there is a risk of perceived improper conduct. Use our electronic system to make your declaration. If you are uncertain about what to declare, ask first, then act. Speak with your line manager. Take time to read and understand this policy, what is acceptable and what is not. This policy should be read in conjunction with the Joint Policy on Standards of Business Conduct.	This Policy supersedes the individual policies of NHS Cornwall and Isles of Scilly and NHS Devon of the same name.
Risks to the ICB if the policy isn't followed	**What could happen if staff don't follow the policy**
If the conflicts of interest policy is not followed, risks could arise: The ICB could face civil challenges to decisions made when conflicts are not properly managed or declared. Breaches of the policy may lead to legal or regulatory penalties, especially if decisions are perceived as biased or unfair. Inhibited free discussion during decision-making processes, which could result in actions or decisions that are not in the best interest of patients or stakeholders Erosion of trust among patients and staff, as the ICB's integrity and transparency may be compromised. Public perception of favouritism, corruption, or mismanagement could damage the ICB's reputation, affecting partnerships and public confidence	Staff who don't follow this policy may be found in breach of it and may face investigation and appropriate action, including disciplinary action or referral to an external agency, in line with the ICB's disciplinary and ICB policies.

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Potential wastage of resources due to decisions influenced by undeclared interests, leading to inefficiencies or misallocation of funds.	

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1. Introduction

1.1 All NHS Devon and NHS Cornwall and Isles of Scilly Integrated Care Boards (ICBs) Board Members and staff have a duty to ensure that all their dealings are conducted to the highest standards of integrity and that NHS monies are used effectively, efficiently and in the best interests of patients.

1.2 Partnerships with other organisations have many benefits and should help ensure that public money is spent well, but there is a risk that conflicts of interest may arise. NHS Devon and NHS Cornwall and Isles of Scilly must ensure the integrity of the processes that it follows when making decisions for its communities, so that they are taken without the influence (or perceived influence) of external or private interests.

1.3 Board Members and staff, as guardians of public money, need to have regard to the Good Governance Standards of Public Services and holders of public office need to uphold the Seven Principles of Public Life, often referred to as the Nolan Principles. (Appendix A).

1.4 Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly (accountability to the public, communities and patients) are also key principles in the NHS Constitution.

1.5 There are also specific statutory requirements for managing conflicts of interest under the National Health Service Act 2006 (as inserted by the Health and Care Act 2022) and under the NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (and related substantive guidance).

2. Purpose

2.1. This policy will support NHS Devon and NHS Cornwall and Isles of Scilly in managing conflicts of interest effectively as it introduces consistent principles and rules for the management of interests.

2.2. This policy should be read in conjunction with the Joint Policy on Standards of Business Conduct Policy.

2.3 This policy is supported by the Declaration of Interest, including Gifts, Hospitality and Sponsorship Standard Operating Procedure (SOP) owned by the Corporate Governance team.

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3. Scope

3.1. This policy applies to all staff, including Board Members, involved in policy-making processes, whether permanent, temporary, or contracted for services (either as individuals or through third-party suppliers).

4. Definitions

4.1 A conflict of interest (COI) is defined by NHS England in its "Managing Conflicts of Interest in the NHS" guidance (2017) as:

"a set of circumstances by which a reasonable person would consider that an individual's ability to exercise judgement or act, in the context of delivering, commissioning or assuring taxpayer funded health and care services, is or could be, or is seen to be or could be seen to be, impaired or influenced by his or her involvement in another role or relationship."

4.2 Interests fall into one of the following four categories:

Financial interests

4.3 Where an individual may get direct financial benefit. This may be a financial gain, or avoidance of a loss from the consequences of a decision they are involved in making. For example:

- A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.
- A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.
- A management consultant for a provider in secondary employment.
- Someone in outside employment, in receipt of a secondary income or a grant.
- Someone in receipt of other payments (eg honoraria, day allowances, travel or subsistence)
- Some in receipt of research sponsorship.

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Non-financial professional interests

4.4 Where an individual may obtain a non-financial professional benefit from

the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career. For example:

- An advocate for a particular group of patients.
- A clinician with a special interest.
- A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needs to be declared).
- An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE).

Non-financial personal interests

4.5 Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career. This could include where an individual is a member of a voluntary sector board or has a position of authority within a voluntary sector organisation or is a member of a lobbying or pressure group with an interest in health and care. For example:

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

Indirect interests

4.6 Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making. A common sense approach should be applied to the term “close association”. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners. For example:

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

- Business partner.

4.7 A conflict of interest may be:

- **Actual** – there is a material conflict between one or more interests.
- **Potential** – there is the possibility of a material conflict between one or more interests in the future.
- **Perceived** – there is a possibility that a reasonably well-informed person could properly have a reasonable belief that an actual conflict of interest exists, even where that is not the case in fact.

4.8 Staff may hold interests for which they cannot see a potential conflict, but others may see the situation differently. The perception of wrongdoing, impaired judgement or undue influence can be as damaging as it actually occurring. All interests should be declared where there is a risk of perceived improper conduct.

4.9 The following table provides other key definitions in respect of Conflicts of Interests:

Terms	Definition
Decision Making Staff	For the purposes of this Policy, NHS Devon and NHS Cornwall and Isles of Scilly follow guidance from NHS England and includes all Board members together with all staff who are graded at 8D and above.
Breaches	There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of deliberate actions. For the purposes of this policy these instances are referred to as “breaches”.
Gifts	A gift is defined as any item of cash or goods, or any service that is provided for personal benefit, free of charge or at less than its commercial value.
Hospitality	For the purposes of this policy hospitality means offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events.
Sponsorship	For the purposes of this Policy sponsorship is funding from an external source, including funding of all or part of the cost of a member of staff, NHS research, staff training,

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Terms	Definition
	pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs, provision of free services (including printing costs) and buildings or premises.
Joint working	Where, for the benefit of patients, organisations pool skills, experience and/or resources for the joint development and implementation of patient-centred projects and share a commitment to successful delivery.

5. What should be declared

5.1 The following provides an overview of the types of interest that should be declared. This list is not exhaustive and if staff have any queries, advice is available from the Corporate Governance team via d-icb.governance@nhs.net

5.2 When considering whether any of the below interests should be declared, staff and organisations should be mindful that they may give rise to the perception of impropriety and might influence behaviour if not handled in an appropriate way.

Loyalty interests

5.3 Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision-making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

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Gifts

5.4 Staff should not accept gifts that may affect, or be seen to affect, their professional judgement:

- Gifts from suppliers or contractors:
  - Gifts offered directly to individuals from suppliers or contractors doing business or likely to do business with the organisation should be declined, whatever their value, and should be declared.
  - Gifts offered to the organisation from suppliers or contractors doing business or likely to do business with the organisation may be accepted on a case-by-case basis to be offered as prizes or gifts to staff as part of a lottery and must be approved by the relevant Chief Officer and Company Secretary and should be declared.
  - Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6 in total and need not be declared. The £6 value has been selected with reference to existing industry guidance issued by the ABPI: https://www.pmcpa.org.uk/media/3406/2021-abpi-code-of-practice.pdf

- Gifts from other sources (for example patients, families, service users):
  - Any personal gift of cash or cash equivalents (for example: vouchers, tokens or offers of remuneration to attend meetings while working for or representing NHS Devon or NHS Cornwall and Isles of Scilly, whatever their value, should always be declined and should be declared.
  - Staff should not ask for any gifts.
  - Modest gifts under a value up to £50 may be accepted and do not need to be declared.
  - Gifts valued at over £50 should be treated with caution and only accepted on behalf of NHS Devon and NHS Cornwall and Isles of Scilly and not in a personal capacity and should be declared by staff. Prior written approval must be obtained from the appropriate line manager following due consideration in cases where it is deemed appropriate to accept a gift of this nature.
  - A common-sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
  - Multiple gifts from the same source over a 12-month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

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Hospitality

5.5 Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.

5.6 Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.

5.7 Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This hospitality can be accepted if modest and reasonable, but approval from a Chief Officer must be obtained and a declaration made.

Meals and refreshments

5.8 Under a value of £25 may be accepted and need not be declared.

5.9 Of a value between £25 and £75 may be accepted and must be declared. (The £75 value has been selected with reference to existing industry guidance issued by the ABPI – Code of Practice, Clause 10.)

5.10 Over a value of £75 should be refused unless (in exceptional circumstances) approval is given in advance by a Chief Officer. A clear reason should be recorded on the Gifts and Hospitality Register as to why it was permissible to accept.

5.11 A common-sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

Travel and accommodation

5.12 Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.

5.13 Offers which go beyond modest or are of a type that the organisation itself might not usually offer, need approval in advance by a Chief Officer, should only be accepted in exceptional circumstances, and must be declared. A non-exhaustive list of examples includes officers of business or first class travel and accommodation (including domestic travel) and offers of foreign travel and accommodation.

Outside employment

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5.14 Staff should declare any existing outside employment (including directorships, self-employment, contracted engagements and other similarly

remunerated situations) to their line manager on appointment and any new outside employment when it arises.

5.15 Board members should disclose any outside employment, along with any other conflicts of interest, as requested during the recruitment process and any new outside employment when it arises.

5.16 Potential conflicts of interest with employment include:

- Employment with another NHS body;
- Employment with another organisation which might be in a position to supply goods or services to the groups;
- Self-employment, including consultancy and/or private practice, in a capacity which might conflict with the work of NHS Devon and NHS Cornwall and Isles of Scilly or which might be in a position to supply goods or services to NHS Devon and NHS Cornwall and Isles of Scilly;
- Directorship of a GP Federation; and
- Working whilst on sick leave.

5.17 Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.

5.18 Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

5.19 The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

Shareholdings and other ownership issues

5.20 Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.

5.21 Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

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5.22 There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

Patents

5.23 Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.

5.24 Staff should seek prior permission from the organisation before, for example, entering into any agreement with bodies regarding product development, research, and work on pathways, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.

5.25 Where holding of patents and other intellectual property rights gives rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

5.26 The Corporate Governance team will keep a register to record all patents / intellectual property. Gains from external work benefitting NHS Devon and NHS Cornwall and Isles of Scilly can give rise to conflicts of interest and actions to take to mitigate the risks should be agreed with the Company Secretary.

Donations

5.27 Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

5.28 Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation.

5.29 Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign.

5.30 Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.

5.31 Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

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Clinical private practice

5.32 Clinical staff should declare all private practice on appointment, and / or any new private practice when it arises including:

- Where they practice (name of private facility);
- What they practice (specialty, major procedures);
- When they practice (identified sessions or time commitment);
- Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed);
- Seek prior approval of their organisation before taking up private practice;
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work;
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non- Divestment_Order_amended.pdf

Sponsored Posts

5.33 Guidance in respect of sponsored events and research can be found in the Joint Policy on Standards of Business Conduct. With regard to sponsored posts:

- Staff who are establishing the external sponsorship of a post should seek formal prior approval.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and confirm the appropriateness of arrangements continuing.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits and auditing arrangements are established.
- Written agreements should detail the circumstances under which organisations have the ability to exit the sponsorship arrangement if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or

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intellectual property relating to or developed in connect with the sponsored post.

6. Declarations – submission, review, management and publication

Making a declaration of interest

6.1 All staff should identify and declare interests at the earliest opportunity (and in any event within 28 calendar days of the circumstances outlined below). If staff have no interests to declare, then a nil return must be made.

6.2 Declarations (including nil returns) should be made:

- On appointment to the organisation.
- When staff move to a new role or their responsibilities change significantly.
- At the beginning of a new project / piece of work / procurement.
- As soon as circumstances change and new interests arise.
- At a meeting should interests staff hold are relevant to the matters in discussion. (See Section 7)
- At an annual review of interests each April.

6.3 Declarations are uploaded and managed by individuals on an online web-portal at https://nhsdevonicb.mydeclarations.co.uk/home, which can also be accessed via a desktop icon. Help and advice on completing and uploading declarations is available from the Corporate Governance team at: d-icb.governance@nhs.net.

Management Actions

6.4 Staff who declare material interests should discuss them with their line manager or the person(s) they are working to and agree a management action plan for mitigation of the risks. The general management actions that could be applied include:

- Restricting staff involvement in associated discussions and excluding them from decision making.
- Removing staff from the whole decision-making process.
- Removing staff responsibility for an entire area of work.
- Removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant.

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6.5 Each case will be different and context-specific, and the Corporate Governance team will clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken. Advice on management actions can be obtained from the Corporate Governance team. In the case of disputes about the most appropriate management action, the individual or their line manager should refer to the Conflicts of Interest Guardian or the Company Secretary.

Review of declarations of interest

6.6 When a Declaration of Interest(s) (DOI) is completed, the Corporate Governance team will check that sufficient information has been provided in order to complete the register and that it has been approved by the line manager of the declarer. The team will request clarification from the declarer if needed.

6.7 The Corporate Governance team will check on materiality of the declaration(s) and ensure there is a suitable management action plan for each material declaration. If any issues arise that are complex or unclear, the Corporate Governance team will refer to the Conflicts of Interest Guardian for advice or a decision.

Publication of registers

6.8 NHS Devon and NHS Cornwall and Isles of Scilly maintain the following registers associated with declarations:

- Declarations of Interest(s)
- Gifts and Hospitality
- Procurement Decisions

6.9 All declared interests that are material will be available on the appropriate register.

6.10 NHS Devon and NHS Cornwall and Isles of Scilly will:

- Publish the interests declared by decision making staff in the appropriate Register on the website.
- Update these Registers at least annually.

Requests for non-publication of interests

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6.11 If decision making staff have grounds for believing that publication of their interests should not take place then they should contact the Corporate

Governance team to explain why. In exceptional circumstances, for instance where the publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers.

6.12 All requests for non-publication will be considered by the Conflicts of Interest Guardian and the Company Secretary. Non-publication of interests will only be agreed as the exception and information will not be withheld or redacted merely because of a personal preference. A confidential, un-redacted version of the register(s) will be kept by the Corporate Governance team.

Leavers

6.13 Register entries for leavers will be removed from the live register and stored separately for a minimum of six years.

Expired Interests

6.14 After expiry, an interest will remain on the register for a minimum of six months. After six months, the Corporate Governance team will remove the interest from the live register and a private record of historic interests will be retained separately for a minimum of six years.

7. Management of interests in meetings

7.1 NHS Devon and NHS Cornwall and Isles of Scilly use a variety of different groups to make key strategic decisions about things such as:

- Approving strategy and long term plans.
- Entering into (or renewing) large scale contracts.
- Making procurement decisions.
- Selection of equipment and services.

7.2 The interests of those who are involved in these groups should be well known so that they can be managed effectively. The principles outlined in this policy apply to all committees and groups that have the power to make decisions on behalf of NHS Devon and NHS Cornwall and Isles of Scilly, such as those in relation to the spending of taxpayers' money, procurements, purchasing of goods, medicines, medical devices or equipment, formulary decisions and contract monitoring.

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7.3 Committees and other decision-making groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declarations of relevant material interests
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise
- Any new interests identified should be added to the organisation's register(s)
- The Vice-Chair (or other non-conflicted member) should chair all or part of the meeting if the Chair has an interest that may prejudice their judgement.

7.4 The default response should not always be to exclude members with interests. Actions to mitigate conflicts of interest should be proportionate and should seek to preserve the spirit of collective decision-making wherever possible. Mitigation should take account of a range of factors including the perception of any conflicts and how a decision may be received if an individual with a perceived conflict is involved in that decision, and the risks and benefits of having a particular individual involved in making the decision. Potential options in relation to mitigation could include:

- including a conflicted person in the discussion but not in decision-making
- excluding a conflicted person from both the discussion and the decision-making
- including a conflicted person in the discussion and decision where there is a clear benefit to them being included in both – however, including the conflicted person in the actual decision should be done after careful consideration of the risk and with proper mitigation in place. The rationale for inclusion should also be properly documented and included in minutes
- excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.

7.5 The Chair of a meeting or committee has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action to manage the conflict of interest.

7.6 If the Chair of a meeting has a conflict of interest, the Vice-Chair is responsible for deciding the appropriate course of action to manage the conflict of interest. If the Vice-Chair is also conflicted then the remaining non-conflicted voting members of the meeting should agree how to manage the conflict(s).

7.7 In making such decisions, the Chair, Vice-Chair or remaining non- conflicted members may wish to consult with the Conflicts of Interest Guardian or Company Secretary.

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7.8 It is imperative that NHS Devon and NHS Cornwall and Isles of Scilly ensure

complete transparency in its decision-making processes through robust record keeping. If any conflicts of interest are declared or otherwise arise at a meeting the Chair must ensure that the following information is recorded in the minutes:

- Who has the interest;
- The nature of the interest and why it gives cause to a conflict;
- The items on the agenda to which the items relate;
- How the conflict was agreed to be managed; and
- Evidence that the conflict was managed as intended.

7.9 The meeting administrator will then ensure that this information is provided to the Corporate Governance team to ensure the accuracy of records.

8. Management of interests during recruitment

8.1 Potential conflicts of interest for Board Members, Chief Officers and roles at Band 8d and above, should be considered during the recruitment process. Following shortlisting for interview, candidates will be asked to complete a Declaration of Interest so that any conflicts can be considered prior to and during interview. NHS Devon and NHS Cornwall and Isles of Scilly will need to consider whether the individual (or anyone they have a close association with) could benefit from any decision NHS Devon and NHS Cornwall and Isles of Scilly might make, which may cause an individual to be excluded from being appointed to the relevant role. These will have to be considered on a case-by-case basis.

8.2 Key considerations when appointing Board Members or Chief Officers include:

- Whether Conflicts of Interest should exclude individuals from appointment.
- Assessing materiality of interests.
- Determining the extent of the interest.

9. Procurement and contract monitoring

9.1 Procurements should be managed in an open and transparent manner, compliant with the NHS Provider Selection Regime and the Procurement Regulations 2024 and other relevant law, to ensure there is no discrimination against or in favour of any provider. Accordingly, the management of interests is required.

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9.2 The management of interests in respect of procurement and contract monitoring is undertaken by the Procurement Team and is governed by the Procurement Policy for all NHS Devon and NHS Cornwall and Isles of Scilly Expenditure.

10. Working with industry and sponsorship

10.1 The Department of Health and Social Care recognises that joint working with the pharmaceutical industry or other third-party organisations, where the benefits to patient care and the difference it could make to their health and wellbeing are clearly advantageous, should be considered by NHS organisations and their employees.

10.2 NHS organisations are required to consider fully the impact of any sponsorship or joint working arrangements on wider healthcare services and the risks of conflicts of interest.

10.3 The approach of NHS Devon and NHS Cornwall and Isles of Scilly to interacting with third party organisations and the potential conflicts of interest which may arise is set out in the Joint Policy on Standards of Business Conduct.

11. Raising concerns and breaches

Identifying and reporting breaches

11.1 There will be situations when interests will not be identified, declared or managed appropriately and effectively or an individual does not follow the agreed mitigating actions. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as “breaches”. Failing to respond to a request for information in relation to this policy, including a request to submit a declaration, will also be considered a breach of this policy.

11.2 Staff who are aware of actual breaches of this policy, or who are concerned that there has been, or may be, a breach should report these concerns to the Corporate Governance team.

11.3 To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised see the Freedom to Speak Up Policy.

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11.4 Each reported breach will be investigated according to its own specific facts and merits and relevant parties will be given the opportunity to explain and clarify any relevant circumstances. Investigations will be organised by the Corporate Governance team and, following investigation, the Conflicts of Interest Guardian and Company Secretary will:

- Decide if there has been or is potential for a breach and if so what the severity of the breach is.
- Assess whether further action is required in response; this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware.
- Take appropriate action.

Taking action in response to breaches

11.5 Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of NHS Devon and NHS Cornwall and Isles of Scilly and could involve the organisational leads for staff support (for example Human Resources), fraud (for example Local Counter Fraud Specialists), or Chief Officers and Directors.

11.6 Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures;
- Consideration as to whether HR, employment law or contractual action should be taken against staff or others;
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Counter Fraud Authority, the Police, statutory health bodies (such as NHS England and Improvement or the CQC), and/or health professional regulatory bodies.

11.7 Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

11.8 Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

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- Employment law action against staff, which might include;
  - informal action (such as reprimand or signposting to training and / or guidance).
  - formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions there might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

11.9 The LCFS works with key colleagues and stakeholders to promote anti-fraud work and effectively respond to system weaknesses and investigate allegations of fraud and corruption. This will include the undertaking of risk assessments to identify fraud, bribery, and corruption risks within NHS Devon and NHS Cornwall and Isles of Scilly.

Learning and transparency concerning breaches

11.10 Reports on breaches, the impact of these, and action taken will be reported to Executives on a six-monthly basis and also to the Audit & Risk Committees meeting in common to ensure lessons are learned, and the management of interests can continually improve.

12. Accountabilities, duties and responsibilities

Chief Executive Officer	The Chief Executive Officer has ultimate accountability for the strategic direction and operational management of the ICB , including compliance with all legal, statutory and policy requirements.

Company Secretary	The Company Secretary is also responsible for (in conjunction with the Conflicts of Interests Guardian):
	• Consider any requests for non-publication of interests.
	• Following any investigation into a potential breach:
	  ○ Deciding if there has been or is potential for a breach and if so what the severity of the breach is.
	  ○ Assessing whether further action is required in response; this is likely to involve any staff member involved and their line manager, as a minimum.
	  ○ Considering who else inside and outside the

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	organisation should be made aware. ○ Taking appropriate action.
Conflicts of Interest Guardian	The Chair of the Audit & Risk Committees meeting in Common is the Conflicts of Interest Guardian. The Guardian is supported by the Company Secretary and Corporate Governance Team to: • Act as a conduit for members of the public and healthcare professionals who have any concerns regarding conflicts of interest. • Be a safe point of contact for staff to raise concerns in relation to this policy and conflicts of interest. • Support the rigorous application of conflicts of interest principles and policies. • Provide independent advice and judgement to staff where there is any doubt about how to apply the Conflicts of Interest Policy. • Provide advice on minimising the risks of Conflicts of Interest. In conjunction with the Company Secretary, the Guardian is also responsible for considering any requests for non-publication of interests and actions following any investigation into a possible breach. (See above.)
Audit & Risk Committee	To receive reports in respect of compliance and any breaches, to take assurance from the policy and processes associated with Conflicts of Interest.
Executives	Receive a six-monthly report in respect of compliance, together with any breaches and the impact of these breaches, to ensure learning and improvement.
Meeting Chairs	Meeting Chairs have responsibility for ensuring that declarations of interest are a standing agenda item and addressed appropriately at the start of all meetings.
Procurement Team	The Procurement team is responsible for managing Conflicts of Interest in respect of procurement and contracts, liaising with the Corporate Governance team as required.

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Corporate Governance Team	The Corporate Governance team is responsible for managing conflicts of interest processes and monitoring compliance.
Recruiting Managers	Managers involved in the recruitment of Board Members, Chief Officers and roles at Band 8d and above, should consider potential conflicts of interest during the recruitment process.
Line Managers	Line managers have a responsibility to ensure their staff comply with the policies and standards within their areas of responsibility including Standing Financial Instructions. Line Managers also have a responsibility to ensure that all conflicts of interest declared by their staff have an appropriate management action plan. Having adequate knowledge of, and / or access to, all relevant legislation in order to ensure that compliance with such legislation is maintained. Ensuring themselves and their teams remain compliant, and relevant declarations are made in line with the policy.
All Staff	All employed or engaged staff (including interim and temporary staff, contractors and seconded staff) have a duty to comply with the policies and standards, including Standing Financial Instructions, as outlined in their contracts of employment and codes of conduct.

13. Impact assessments

13.1 An Equality Quality Impact Assessment (EQIA) has been completed in respect of this policy. No concerns were highlighted.

14. Implementation

14.1 Staff will be informed of the approval of the Policy via the Staff Bulletin, which will provide a link to the document on the Intranet.

14.2 Training on conflicts of interest forms part of the mandatory annual training programme for all staff and is delivered through online modules accessible via the Electronic Staff Record.

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14.3 In addition to the mandatory training, the Corporate Governance team will provide awareness sessions to staff via Staff Briefings and articles in the Staff Bulletin.

14.4 This policy is subject to approval of the NHS Devon and NHS Cornwall and Isles of Scilly Integrated Care Boards following recommendation from the Audit & Risk Committees meeting in common.

15. Monitoring Compliance and Effectiveness

15.1 The effectiveness of how NHS Devon and NHS Cornwall and Isles of Scilly manage conflicts of interest and complies with this policy will be the subject of an annual internal audit. The outcome of this audit is presented to the Audit & Risk Committees meeting in common and reported in the annual Head of Internal Audit Opinion.

15.2 The Chief Executive Officer will review compliance and effectiveness as part of the Annual Report process, which includes the consideration of the Head of Internal Audit Opinion.

15.3 Compliance with conflicts of interest processes will be monitored by the Corporate Governance Team, who will report to the Audit & Risk Committees meeting in common bi-annually in respect of compliance, together with any breaches and the impact of these breaches, to ensure learning and improvement.

15.4 Any trends resulting from non-compliance will be raised with staff through management routes.

16. Review

16.1 This policy will be reviewed annually or sooner in the event of changes to legislation, national guidance or the local context.

17. References

17.1 This policy should be read in conjunction with the following associated policy documents:

- Joint Policy on Standards of Business Conduct
- Procurement Policy for all ICB Expenditure

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- Freedom to Speak Up Policy
- Anti Fraud and Bribery Policy
- Standing Financial Instructions
- Scheme of Reservation and Delegation

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APPENDIX 1 – Nolan Principles

1. **Selflessness**
   Holders of public office should act solely in terms of the public interest. They should not do so to gain financial or other benefits for themselves, their family or their friends.

2. **Integrity**
   Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

3. **Objectivity**
   In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

4. **Accountability**
   Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

5. **Openness**
   Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

6. **Honesty**
   Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

7. **Leadership**
   Holders of public office should promote and support these principles by leadership and example.

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APPENDIX 2 – External references

Legislation and statutory requirements

- Bribery Act 2010: www.legislation.gov.uk/ukpga/2010/23/contents www.gov.uk/government/publications/bribery-act-2010-guidance
- Fraud Act 2006: www.legislation.gov.uk/ukpga/2006/35/contents
- National Health Service Act 2006: www.legislation.gov.uk/ukpga/2006/41/contents
- Health and Care Act 2022: www.legislation.gov.uk/ukpga/2022/31/contents/enacted
- NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013

15.3 Best practice recommendations and other key guidance

- Department of Health - Confidentiality: NHS Code of Practice: www.gov.uk/government/publications/confidentiality-nhs-code-of-practice
- General Medical Council (GMC) : www.gmc-uk.org/guidance/good_medical_practice.asp www.gmc-uk.org/guidance/ethical_guidance.asp www.gmc-uk.org/about/council/register_code_of_conduct.asp
- Good Governance Standards of Public Services: www.jrf.org.uk/report/good-governance-standard-public-services
- NHS Counter Fraud Authority: cfa.nhs.uk/
- NHS England - Standards of Business Conduct for NHS Staff: www.england.nhs.uk/publication/standards-of-business-conduct-policy/
- NHS England – Managing conflicts of interest in the NHS: www.england.nhs.uk/long-read/managing-conflicts-of-interest-in-the-nhs/
- Seven Key Principles of the NHS Constitution: www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs- constitution-for-england

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Joint Policy on Risk Management

NHS Devon
NHS Cornwall and Isles of Scilly

Document Reference	Policy on Risk Management
Version	V1
Senior Responsible Officer	Company Secretary
Author/s	Head of Corporate Governance
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Date Approved	28 May 2026
Date Issued	1 June 2026
Date of next Review	31/03/2027

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Equality, diversity and inclusion statement

NHS Devon and NHS Cornwall and Isles of Scilly are committed to promoting equal opportunities, addressing health inequalities, and fostering good relations between people protected under the Equality Act 2010, the Health and Social Care Act 2012, and Human Rights legislation. We are equally committed to eliminating unlawful discrimination, harassment, and victimisation. To demonstrate this commitment, we develop, promote and maintain policies, strategies and operating procedures. Every effort is made to ensure that patients, employees, contractors or visitors do not experience discrimination; either directly or indirectly, because of their vulnerability; disadvantage; age, disability; gender reassignment; marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex (gender) or sexual orientation.

All staff must comply with this policy. Compliance must reflect our organisational commitment to and policy on equality, diversity and inclusion. In addition, each manager and member of staff involved in implementing this policy must give due regard to the needs of those protected under law.

If you, or any other groups, believe you are discriminated against under the terms of the Equality Act, the Health and Social Care Act 2012 or Human Rights legislation by anything contained in this document; or you need this document in an alternative format, for example, large print, Braille, Easy read or other languages; please contact our Patient Advice and Complaints Team (PACT):

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Policy Summary

Summary & Key Aims	Target Audience
Aim: Acknowledge that risk exists and empower staff to assess, record, and manage it by severity, report it, and scrutinise it within NHS Devon, NHS Cornwall and Isles of Scilly. **Purpose:** Provide a comprehensive risk management and assurance framework covering organisational, financial, clinical, and non-clinical risks, engaging all parts of the ICB.	All staff (including interim and temporary staff, contractors and seconded staff) have a duty to comply with this Policy.
Key Requirements	**Previous Policy Names**
Risk management is everyone's responsibility. Staff must cooperate with managers, identify risks, and advise their line managers. Key responsibilities include: Be familiar with and follow the Joint Policy on Risk Management, along with all relevant policies and procedures. Report incidents, accidents, and near misses per the Incident Reporting Policy. Be aware of legal duty to ensure personal and others' safety. Comply with NHS Devon, NHS Cornwall, and Isles of Scilly rules to safeguard health, safety, and welfare.	This Policy supersedes the individual policies of NHS Cornwall and Isles of Scilly and NHS Devon of the same name.
Risks to the ICB if the policy isn't followed	**What could happen if staff don't follow the policy**
Not following the risk management policy can lead to increased unmanaged risks threatening strategic objectives and duties, failure to address strategic risks, regulatory scrutiny, operational disruptions, reputational damage, and financial or legal liabilities, including potential collapse.	If an employee fails to follow the agreed-upon risk mitigation measures, the consequences may vary based on the severity of the violation. The employee's reputation within the ICB may suffer. The employee may be required to undergo additional training or retraining to address knowledge gaps or compliance issues.

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1. Introduction

1.1. Risk management plays a critical role in helping NHS Devon and NHS Cornwall and Isles of Scilly Integrated Care Boards (ICBs) understand and manage risks to the achievement of its priorities. It helps us to determine an appropriate control environment and balance of strategies to manage risk, so we use resources efficiently and effectively. It involves making decisions and establishing governance systems that embed and support effective risk processes, and building an organisational culture that upholds integrity, accountability, honesty, openness, and responsiveness to change.

1.2. This policy sets out the key principles that guide risk management within NHS Devon and NHS Cornwall and Isles of Scilly.

1.3. Further advice and guidance are available from the Corporate Governance team:

d-icb.governance@nhs.net (NHS Devon)

ciosicb.corporategovernance@nhs.net (NHS CIOS)

2. Purpose

2.1. Risks will always occur. Many risks are manageable, but others pose a greater risk of impact on the organisation, staff, patients, and /or the general public. Once identified, risks must be assessed, recorded, managed according to severity, reported and scrutinised.

2.2. NHS Devon and NHS Cornwall and Isles of Scilly are required by statute and by guidance from the Department of Health and Social Care (DHSC) to systematically identify and control all significant strategic and operational risks. These arise across the organisation, including clinical and corporate services.

2.3. The Boards of NHS Devon and NHS Cornwall and Isles of Scilly (through the South West Peninsula Board) set the organisational strategy from which risks to delivery are identified; the Board is required to ensure that robust risk management processes exist, it is assured that there are systems in place to control and manage risk and that these systems are working effectively. This involves the proactive identification and management of risks that may threaten the achievement of NHS Devon and NHS Cornwall and Isles of Scilly objectives, its statutory or regulatory duties, and its response to adverse events or to learning from audits and other independent reviews.

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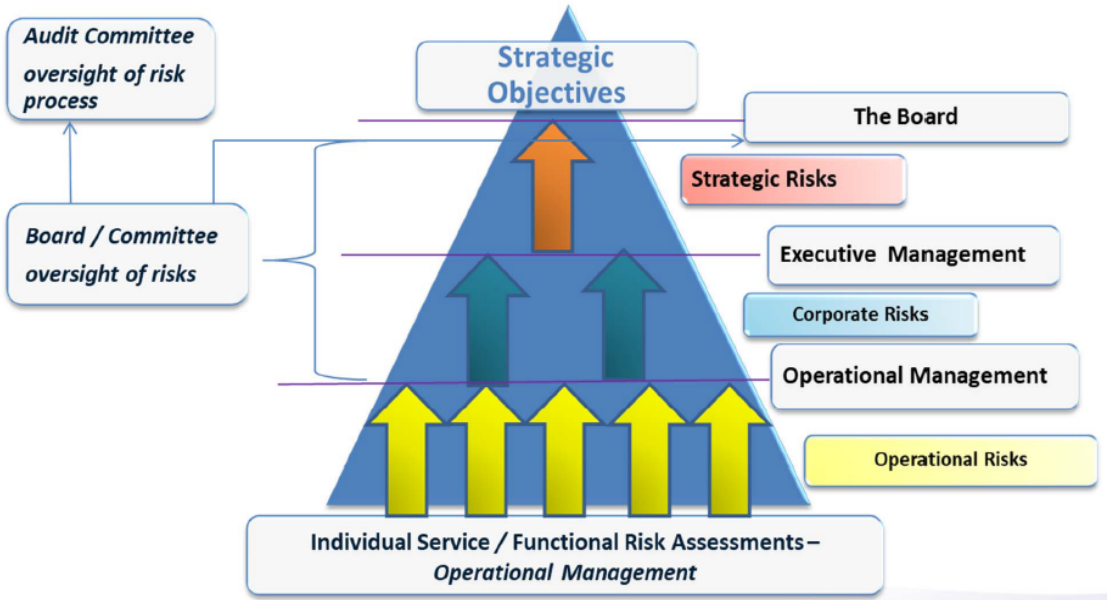
2.4. Figure 1 shows the flow of risk between operational, corporate and strategic levels

Figure 1: Risk Hierarchy



2.5. It should be noted that the primary focus across healthcare systems is population health, but there is a clear distinction between the objectives of each organisation within the health system. Whilst partner provider organisations (e.g., Acute, Community and Mental Health Trusts) are directly accountable for patient safety, typically Integrated Care Boards (ICBs) face risks around the visibility of patient safety, challenges in identifying and investigating cross-organisational risks, resource constraints, and potential declines in performance and financial stability due to mergers and cuts in running costs. Should such risks materialise, NHS Devon and NHS Cornwall and Isles of Scilly ICB's duty to commission and oversee statutory health system functions effectively could be adversely affected, resulting in reputational damage and a lack of public confidence.

2.6. This policy applies to all employees and Committee Members of NHS Devon and NHS Cornwall and Isles of Scilly:

- Establishes a framework for risk management and board assurance which embraces organisational, financial, clinical, and non-clinical risks and in which all parts of the organisation are involved.
- Provides an environment for proactive decision making.
- Empowers all staff to manage risk within delegated limits.
- Provides a proactive early warning system and enable a comprehensive response to mitigate risk where indicated.

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- Establishes a platform for managing risks within partnership working.
- Ensures the integration of risk management with the NHS Devon and NHS Cornwall and Isles of Scilly's strategies and objectives and with local (directorate / team) objectives that these support.

2.7. This policy also helps to reduce the risk of fraud and bribery by providing a robust system of internal control for risk management. It supports and complements NHS Devon and NHS Cornwall and Isles of Scilly's Counter Fraud, Bribery and Corruption Policy and has been reviewed by the organisation's Local Counter Fraud Specialist. Fraud and bribery risks may be included in NHS Devon and NHS Cornwall and Isles of Scilly risk registers and its performance against standards will be assessed annually via completion of the NHS Counter Fraud Authority (CFA) Counter Fraud Functional Standard Return.

2.8. NHS Devon and NHS Cornwall and Isles of Scilly recognise that risk management is an integral part of good management practice and an effective corporate governance framework and, to be most effective, it must become part of the organisation's culture. The South West Peninsula Board is therefore committed to ensuring that risk management forms a part of NHS Devon and NHS Cornwall and Isles of Scilly philosophy, practice, and planning, rather than being viewed or practised as a separate programme, and that responsibility for implementation is accepted at all levels of the organisation.

2.9. NHS Devon and NHS Cornwall and Isles of Scilly acknowledge that the provision of appropriate training is central to the achievement of this aim.

2.10. A critical role of any Board is to focus on the risks that may compromise the achievement of the organisation's strategic and corporate objectives, its statutory or regulatory duties. To be confident that internal control systems are robust, NHS Devon and NHS Cornwall and Isles of Scilly must provide evidence that they have systematically identified their strategic objectives and managed the principal risks to achieving them. Evidencing assuring through specific documentation is a key feature of the NHS Devon and NHS Cornwall and Isles of Scilly risk management system, **4risk** (see paragraph 7.4 for more information on levels of assurance).

2.11. NHS Devon and NHS Cornwall and Isles of Scilly are committed to the following key principles:

- **A Just Culture** – Staff reporting or directly involved in incidents are assured that any investigation will be carried out fairly, openly, transparently, without prejudice and with the aim of identifying learning and correcting underlying causes of the incident to prevent recurrence.

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- **Freedom to Speak Up (Whistleblowing)** – All staff should be familiar with the NHS Devon and NHS Cornwall and Isles of Scilly Freedom to Speak Up: Raising Concerns (Whistleblowing) Policies, available on the staff intranet, which sets out procedures and guidance to staff on raising concerns. NHS Devon and NHS Cornwall and Isles of Scilly have Freedom to Speak Up Guardians to whom staff may raise concerns; their details are available on the staff intranet.

3. Definitions

3.1. For a full glossary of terms used within this policy document and in risk management in general, please refer to Appendix 1.

3.2. **A risk** is defined as:

"The effect of uncertainty on objectives".

(ISO31000: 2018)

For example, the potential occurrence of an event that may have an impact on strategic objectives, duties, assets and / or reputation of the organisation.

3.3. In particular:

- Any element which has the potential to damage or threaten the achievement of the statutory or regulatory duties, strategic and corporate objectives, programmes, or service delivery of NHS Devon and NHS Cornwall and Isles of Scilly.
- Anything that could damage the reputation of NHS Devon and NHS Cornwall and Isles of Scilly and undermine the public's confidence in NHS Devon and NHS Cornwall and Isles of Scilly.
- Failure to guard against impropriety, malpractice, waste and / or poor value for money.
- Non-compliance with regulations and / or legislation such as those covering health and safety, safeguarding and the environment.
- An inability to respond to, or manage, changed circumstances in a way that prevents or minimises adverse effects on the delivery of NHS Devon and NHS Cornwall and Isles of Scilly's statutory or regulatory duties, strategic and corporate objectives.

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3.4. NHS Devon and NHS Cornwall and Isles of Scilly distinguish between **inherent risks and residual risks**. An inherent risk is one that is

unmitigated whilst a residual risk is the risk that remains once the inherent risk has been mitigated or managed. Appendix 2 provides an illustration of the difference between these two types of risk.

3.5. **An issue** is an event that has happened or is happening. It is a 'known' as opposed to an 'unknown' quantity. The outcome of the actions and events is no longer subject to uncertainty as in the case of a risk. The consequences may be observed and measured. However, that is not to say that new risks will not emerge as the 'issue' continues.

3.6. In simplistic terms, the difference comes down to whether the event has the **potential to occur** (i.e. it is a risk) or has **already occurred** and the impact / consequence is now present (i.e. it is an issue).

3.7. Appendix 3 provides more detailed information on the key differences between risks and issues. NHS Devon and NHS Cornwall and Isles of Scilly do not hold a corporate issue log.

3.8. Risk management within NHS Devon and NHS Cornwall and Isles of Scilly will be carried out in accordance with the principles set out in Appendix 4. Examples include alignment with objectives, fits the context, promotes, guides, and supports a clear and consistent approach, informs decision-making, facilitates continual improvement, and achieves measurable value.

4. Risk Management Activities and Processes

4.1. Risk management involves the following activities (see Appendix 5):

- **Identify the risk:** Consider how and why the successful achievement of a goal / objective might be prevented. Hazards, barriers, and challenges to achievement of objectives, at strategic and operational level, can be identified from a variety of internal and external sources such as staff resource issues, workforce recruitment problems, incompatibility of IT systems, a lack of assurance on areas of quality and performance data or information from staff and / or patients etc.

- **Assess the risk:** Describe the risk and give it a succinct title which clearly identifies the risk, the area to which it relates and, where appropriate, the financial year to which it relates. Consider how the risk could occur, who or what might be involved, what the effect(s) would be if the risk were to materialise and how this could be reduced or minimised. Describe the risk clearly and concisely; think in terms of the "**if**", "**then**", "**resulting in**" statement e.g. **if** (the cause – why the risk is happening), **then** (the risk event, that if it happened, could have an

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impact on objectives) **resulting in** (the effect or impact of the risk – what will happen if the risk materialises).

- **Analyse, evaluate and score the risk:** Assess the likelihood of the risk materialising, and the level of its impact should it occur using the risk score matrix. Note: all assessments must be based on the likelihood and impact domains set out in Appendix 6. The calculated risk score will determine whether the risk is managed at the team/directorate level or via the NHS Devon and NHS Cornwall and Isles of Scilly Corporate Risk Register (CRR).

- **Treat the risk:** Determine which of the following actions will be required:

Treatment	Treatment Description
Treat	Draw up a specific action plan (which includes consideration of funding / associated costs) to reduce the impact or likelihood scores to an acceptable level, as articulated in the 'risk appetite' agreed by the South West Peninsula Board, in order to gain further control.
Tolerate	It is not always possible to identify and then fully implement actions that eliminate or minimise the risk. Where this is the case, it is essential that the significance of the risk that remains (the residual risk) is understood and the organisation, in accordance with the level of authority for risk management, confirms that it is prepared to accept that level of risk.
Transfer	Transfer the risk to another organisation (this is rare).
Terminate	Close the risk (subject to approval) – for example, decide to no longer do the activity that is causing the risk.

- **Report the risk:** all identified risks should be recorded on a risk register; the risk score determines where it is reported:

  All team / directorate risks (generally scoring 10 or below) are reported and managed locally via a team / directorate risk register. The risk register should be reviewed and updated monthly and escalated to the relevant Chief Officer as required.

  A quarterly review of all team / directorate risk registers should be undertaken by the Corporate Governance team to ensure oversight

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of any risks that may need to be escalated. Note: it is the risk owner's responsibility to raise awareness about the risk.

All teams / directorates should maintain their own risk registers.

If a risk is deemed to be a risk to the achievement of NHS Devon and NHS Cornwall and Isles of Scilly's statutory or regulatory duties, corporate objectives or statutory purposes, and not just those of the team / directorate, and scores 12 or above, then it can be escalated for inclusion on the NHS Devon and NHS Cornwall and Isles of Scilly Corporate Risk Register (CRR).

All project / programme risks (any score) are reported and managed locally via a project / programme risk register. The risk register should be reviewed regularly by the Project / Programme Manager. Where there is a significant risk to the non-achievement of the project / programme objective which may then pose a further risk to the achievement of an organisational statutory or regulatory duty, objective, operational or strategic, the Project / Programme Manager will discuss with the most senior officer with portfolio responsibility for the risk and seek advice and guidance from the central Corporate Governance team as appropriate.

All operational risks (generally with a validated residual score of 12 and above) are added to the NHS Devon and NHS Cornwall and Isles of Scill**y** Corporate Risk Register (CRR); this is done in conjunction with a member of the Corporate Governance team. Operational risks are reviewed monthly. The review is overseen by a member of the Corporate Governance team.

Extreme operational risks (scoring 15 and above) are reported alongside the Board Assurance Framework (BAF) to NHS Devon and NHS Cornwall and Isles of Scilly Chief Officers.

All strategic risks are included on the Board Assurance Framework (BAF) and are reviewed regularly and reported alongside corporate risks to Chief Officers and the South West Peninsula Board, and where appropriate, its associated Assurance Committees.

Refer to Appendix 7 for a summary of risk action and reporting requirements.

- **Monitor / review the risk:** Monitor the risk impact and review the effectiveness of action / actions taken. It is expected that the risk score / risk priority has changed as a result.

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- **Communicate with and consult those impacted by the risk:** It is the risk owner's responsibility to identify who is affected by the risk and who needs to know about it, e.g. internally and/or externally.

5. Risk impact domains

5.1. In NHS commissioning, risk management frameworks are essential to ensure that commissioned services are safe, effective, and deliver value for money. Risk impact domains provide a structured way to identify, assess, and manage risks across different aspects of commissioning.

Safety and Quality of Care

- Example: Risk that a commissioned provider fails to meet infection control standards, leading to patient harm.
- Guidance: Commissioners include safety indicators in contracts, conduct quality assurance visits, and require incident reporting.

Clinical Effectiveness

- Example: Risk that services do not follow NICE guidelines, resulting in suboptimal patient outcomes.
- Guidance: Commissioners specify clinical standards in service specifications and use audit data to assess compliance. They may commission clinical reviews or second opinions.

Workforce and Staff Wellbeing

- Example: Risk that provider staff burnout affects service quality.
- Guidance: Commissioners consider workforce sustainability in service design, support staff wellbeing initiatives, and include workforce metrics in performance reviews.

Regulatory and Legal Compliance

- Example: Risk of non-compliance with NHS England commissioning regulations or data protection laws.
- Guidance: Commissioners ensure contracts include compliance requirements, provide training on legal obligations, and conduct regular compliance audits.

Publicity and Stakeholder Confidence

- Example: Risk that poor service quality leads to negative media coverage and loss of public trust.
- Guidance: Commissioners engage with patient groups, maintain transparent communication, and have crisis management plans. They also monitor media and social media sentiment.

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Business Objectives

- Example: Delays or underperformance in implementing new care pathways or service transformation projects, leading to missed health outcomes or efficiency targets.
- Guidance: Commissioners establish clear roles and responsibilities for risk ownership. Ensure leadership oversight through committees and board reporting.

Financial and Resource Management

- Example: Risk of overspending on commissioned services or fraud.
- Guidance: Commissioners implement robust financial controls, regular audits, and value-for-money assessments. They may use activity and cost data to detect anomalies.

Information Governance and Cybersecurity

- Example: Risk of data breaches in shared patient records systems.
- Guidance: Commissioners require providers to adhere to NHS Digital standards, conduct data protection impact assessments, and monitor cybersecurity incidents.

5.2. The risk impact risk scoring matrix can be seen at Appendix 6

6. Strategic and Operational Risks

6.1. Risk-related activity within NHS Devon and NHS Cornwall and Isles of Scilly is derived from two directions:

- **Top down:** NHS Devon and NHS Cornwall and Isles of Scilly Boards and the South West Peninsula Board discuss and agree those strategic risks that they consider the ICBs face in the achievement of their statutory or regulatory duties, agreed corporate objectives or other statutory functions. These form the strategic risks of NHS Devon and NHS Cornwall and Isles of Scilly and are recorded in their Board Assurance Frameworks (BAFs).

- **Bottom up:** Individuals, teams, directorates, Chief Officers, the South West Peninsula Board, and its Board Assurance Committees can identify a risk, and this risk would then be recorded and managed accordingly in accordance with the details laid out in this policy document. These risks are operational risks. Those risks scoring 10 or below are included on team / directorate risk registers and those scoring 12 or above form the NHS Devon and NHS Cornwall and Isles of Scilly Corporate Risk Register (CRR).

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6.2. Both operational and strategic risks should be aligned to NHS Devon and NHS Cornwall and Isles of Scilly's statutory or regulatory duties and objectives (as articulated in the Integrated Care Strategy and Joint Forward Plan (JFP)). In the absence of corporate objectives at any point, operational and strategic risks should be expressed and recorded against one of the four statutory purposes of Integrated Care Boards:

- Improve outcomes in population health and healthcare.
- Reduce health inequalities in outcomes, experience, and access.
- Enhance productivity and Value for Money (VfM).
- Support broader social and economic development.

6.3. Risk Scores are calculated in accordance with the National Patient Safety Agency (NPSA) Model Risk Matrix and are the product of the impact/consequence and the likelihood of the risk arising (see Appendix 6).

6.4. NHS Devon and NHS Cornwall and Isles of Scilly adhere to the Nolan Principles of openness and accountability, however occasionally there is the requirement to make a risk confidential which means that it is not reported within the public domain. A risk can be classified as confidential with the approval of the Corporate Governance team and the Chief Officer if it contains clinically or commercially sensitive information. The classification of a risk as being confidential due to clinically sensitive information also requires the approval of either the Chief Place and Transformation Officer or the Chief Clinical Officer.

7. Corporate Risk Register (CRR)

7.1. **Risk escalation, de-scalation and moderation** - All teams / directorates should maintain their own risk registers. If a risk is deemed to be a risk to the achievement of NHS Devon and NHS Cornwall and Isles of Scilly's statutory or regulatory duties or corporate objectives, and not just those of the team or directorate, and score 12 or above, then it can be escalated for inclusion on the NHS Devon and NHS Cornwall and Isles of Scilly Corporate Risk Register (CRR). The Risk Management Group* reviews any such risk with the risk assessor and owner to determine whether it is appropriate and whether the scoring is proportionate. If the risk is deemed appropriate for inclusion, it is added to the NHS Devon and NHS Cornwall and Isles of Scilly Corporate Risk Register (CRR).

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7.2. **Risk Management System** – All managers have a responsibility to record identified corporate risks on the NHS Devon and NHS Cornwall and Isles of Scilly risk management system (4risk). This ensures risks at all levels are held in a central location which is fully auditable (please contact the Corporate Governance team for access to and training on how to use the

risk management system if required). The risk management system allows staff to add new risks (once appropriately approved) or update existing ones at any time. Corporate risks must be reviewed and updated by the named assessor in line with 4risk rules (e.g., red-rated risks must be reviewed at least monthly to be compliant). Following this review the update will be agreed by the risk owner and reported as appropriate.

7.3. Regular reviews are undertaken across NHS Devon and NHS Cornwall and Isles of Scilly to ensure that:

- New risks are identified and assessed.
- A careful watch is maintained on cumulative risk NHS Devon and NHS Cornwall and Isles of Scilly to ensure that this is identified and properly escalated via the Risk Management Group.
- Existing risks and their mitigating actions are tracked and kept up to date.
- A summary of all incidents within teams / directorates is reviewed and this information is disseminated to ensure that appropriate learning takes place to reduce future risks.
- Risks that are no longer being faced by NHS Devon and NHS Cornwall and Isles of Scilly are closed.

7.4. **Assurance** should be provided using the Three Lines (of defence) model to govern our risks and demonstrate that we are managing the organisation well. The three lines model provides a structure for describing the assurance activity related to risk management across the organisation. It gives regions and corporate teams autonomy for identifying, managing and reporting risk; with our specialist functions such as the corporate risk management and legal teams providing oversight; and internal/external audit providing independent assurance.

<u>The first line of defence</u>

7.5. The first line of defence relates to functions that own and manage risk. Staff and managers working within ICB teams have direct ownership, responsibility, and accountability for identifying, managing and controlling risks to their objectives. Assurance is provided through the monitoring and reporting of risk and control activities through senior leadership/management team meetings. This can include the review of performance metrics, deep dive reviews of concern areas, etc. and it is ongoing.

<u>The second line of defence</u>

7.6. The second line of defence relates to functions that oversee or specialise in risk management and compliance. They guide, support, and challenge the first line by bringing expertise and subject matter knowledge to help ensure risks and controls are effectively managed and assured. The Corporate Governance team, and other internal oversight teams such as legal, IT,

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performance/business planning, finance and HR (among others) form the second line of defence and are responsible for co-ordinating, facilitating and overseeing the organisation's effectiveness and integrity. Each directorate and should consider and document how the second line will be enacted within their area of the organisation, such as raising awareness across senior leadership teams and Board Assurance Committees.

The third line of defence

7.7. The third line of defence relates to functions that provide independent assurance, namely audit. It provides assurance to senior management and the Board over both the first and second lines' efforts. Internal audit and external scrutiny through the National Audit Office provide independent, objective assurance and challenge concerning the integrity and effectiveness of risk management and internal control. Assurance is provided through monitoring and reporting of strategic/corporate risk and control activities through the Audit and Risk Committee (ARC)

7.8. The full process for the identification, scoring, management and reporting of risks is detailed within the Standard Operating Procedures (SOPs) that support this policy document.

8. Board Assurance Framework (BAF)

8.1. The BAF provides a structure and process that enables NHS Devon and NHS Cornwall and Isles of Scilly to focus on the risks that might compromise achieving its most important goals and objectives, to map the controls that should be in place to manage those risks, and to confirm that the Board has sufficient assurance regarding the effectiveness of those controls.

8.2. In advance of each financial year, NHS Devon and NHS Cornwall and Isles of Scilly should agree on overarching strategic objectives for that year underpinned by several corporate objectives. The BAF captures these strategic objectives and the strategic risks applicable to them. Each objective, along with the strategic risks associated with it, will be assigned to a Board Assurance Committee to ascertain levels of assurance through scrutiny, monitoring, testing and challenge of controls through associated evidence. Operational and strategic risks may also be expressed and recorded against one of the four Statutory Purposes for Integrated Care Boards, those being:

- Improve outcomes in population health and healthcare.
- Reduce health inequalities in outcomes, experience, and access.
- Enhance productivity and Value for Money (VfM).

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- Support broader social and economic development.

8.3. Any Board Assurance Committee responsible for scrutinising an area of risk to the delivery of one or more strategic objectives can recommend the escalation of a risk to the Board when one or more of the following criteria are met:

- The current score is considered to be significantly in excess of the target score by the committee.
- It is a long-standing risk that shows little or no reduction in the current risk score; or
- The Committee has not received sufficient assurance that the risk is being appropriately and effectively managed.

8.4. The BAF is routinely updated by Chief Officers in conjunction with the Corporate Governance team and reported to NHS Devon and NHS Cornwall and Isles of Scilly Chief Officers for recommendation to the South West Peninsula Board. The BAF will set out the controls, assurances, and mitigating actions. The details in relation to mitigating actions will also require an 'action owner', the 'action status' and 'planned implementation date' to be recorded; this is so that progress against plan can be monitored, and corrective action taken where there is deviation from plan.

8.5. The BAF will be used as a tool for setting the agendas of Board meetings and development sessions (as well as Board Assurance Committee agendas). To be an effective tool, it should be possible to map items identified in the BAF to papers presented to the meeting which address those items. This may be through specific papers, or within standing agenda items such as finance, quality and performance reports.

9. Risk Appetite

9.1. NHS Devon and NHS Cornwall and Isles of Scilly's **Risk Appetite Statement** documents the delegation of risk taking from the Board to senior management. It specifies the overall risk levels that the Board is willing to accept whilst operating in full compliance with regulatory and legal requirements.

9.2. **Risk appetite** is defined as "the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic aims and objectives" and is key to achieving effective risk management. It can be influenced by personal experience, political factors, and external events.

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9.3. It represents a balance between the potential benefits of innovation and the threats that change, and improvement inevitably bring. It should be at the heart of the systems and processes in place to manage risk within NHS Devon and NHS Cornwall and Isles of Scilly, as well as how decisions are taken.

9.4. NHS Devon and NHS Cornwall and Isles of Scilly, through the South West Peninsula Board, should articulate, as part of the annual risk cycle, its appetite in relation to each of the statutory or regulatory duties or corporate objectives, expressed using the following framework:

Risk Appetite Level	Risk Tolerance Level
Very Low	1-5
Low	6-10
Moderate	11-15
High	16-20
Very High	21-25

9.5. Based on risk appetite, a 'target' risk score is set for individual risks; this is the level to which the risk is managed. The benefits of this approach include:

- Management focuses on risks that can be managed / reduced
- Identification of targeted actions to reduce risks to 'target'
- Timely reduction of risks
- Identification of static risks / ineffective actions *and*
- Management focuses on risks that are not being reduced

9.6. The process for setting and reviewing risk appetite (including 'target' risk scores) is detailed in Appendix 8 together with the current risk appetite statement agreed by the South West Peninsula Board.

10. Accountabilities and Responsibilities

10.1. NHS Devon and NHS Cornwall and Isles of Scilly, operating through the South West Peninsula Board, are ultimately responsible for the organisation's systems of internal control (financial, organisational, clinical, and non-clinical) and risk management arrangements, and for demonstrating leadership, active involvement, and support for risk management across the organisation. They are supported in the discharge of their responsibilities by the Audit and Risk Committees meeting in

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common (ARC), Risk Management Group, other Assurance Committees, and the NHS Devon and NHS Cornwall and Isles of Scilly Chief Officers.

10.2. The South West Peninsula Board receives assurance as to whether operational and strategic risks are being effectively managed. It reviews and approves the Board Assurance Framework (BAF) regularly to monitor actions and assurances against strategic risks and assesses the overall impact on the delivery of NHS Devon and NHS Cornwall and Isles of Scilly's statutory/regulatory duties and corporate objectives.

10.3. In addition to the above, it is also responsible for determining the risk appetite of NHS Devon and NHS Cornwall and Isles of Scilly and for approving the Joint Policy on Risk Management.

10.4. The **Risk Management Group** (RMG) is chaired by the Company Secretary and constituted by key members of the senior leadership team, overseeing the risk environment of NHS Devon and NHS Cornwall and Isles of Scilly at an operational level and provides assurance to the ARC on the efficacy of the risk control system. RMG challenges risks identified and presented by directorates, validating new and/or escalating risks for inclusion on the Corporate Risk Register as appropriate. RMG also recommends new and/or escalating risks for consideration by the South West Peninsula Board for the inclusion within the Board Assurance Framework. The core purpose of RMG is to:

- Moderate risk scoring of all risks and ensure due process (as described within this policy) has been observed in all cases
- Review all risks with a risk score of 15 or above as a standing item
- Ensure all existing and new risks have appropriate assurances in place
- Rank the validated risks in priority order to inform Executive Directors, Assurance Committees, System Capital Meeting and the Board

10.5. The **Audit and Risk Committee** (ARC) provides an objective view on internal control and risk management systems to NHS Devon and NHS Cornwall and Isles of Scilly that is independent of Chief Officers. ARC also:

- Reviews the adequacy and effectives of the system of integrated governance and risk management and internal control across the whole of NHS Devon and NHS Cornwall and Isles of Scilly activities that support the achievement of its objectives, and to highlight any areas of weakness to the South West Peninsula Board.
- Reviews the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of NHS Devon and NHS Cornwall and Isles of Scilly's statutory/regulatory duties or objectives, the effectiveness of the management of principal risks.

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- Maintains oversight of organisational and system risks where they relate to the achievement of NHS Devon and NHS Cornwall and Isles of Scilly's statutory or regulatory duties or objectives; the Board maintains overall responsibility for risk management.
- Seeks reports and assurance from RMG, directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
- Reviews the outcome of the annual internal audit of governance and risk management arrangements which, along with other assurances received, will enable the committee to recommend the Annual Governance Statement is signed off by the Chief Executive Officer (CEO) at the end of each financial year.
- Identifies opportunities to improve governance, risk management and internal control processes across NHS Devon and NHS Cornwall and Isles of Scilly.

10.6. The Chair of the ARC will provide a summary to NHS Devon and NHS Cornwall and Isles of Scilly of its assurances and where necessary, request assurance reports to be undertaken in areas of risk where further assurances are required.

10.7. The **Head of Internal Audit** (HoIA) is responsible for implementing a programme of verification to ensure that the risk management systems and controls the NHS Devon and NHS Cornwall and Isles of Scilly have in place are sufficient and will enable the provision of an audit assurance opinion to the Chief Executive Officer (CEO) and the ARC.

10.8. **Board Assurance Committees** have specific roles in relation to the statutory / regulatory duties or strategic risks assigned to them and as set out in their Terms of Reference.

10.9. NHS Devon and NHS Cornwall and Isles of Scilly **Chief Officers** provide oversight and delivery of risk management arrangements. Seek assurance from RMG to review whether individual operational risks are being effectively managed and whether the action plans are sufficient and having the desired effect within the agreed timescales. In addition, they regularly have oversight of the Board Assurance Framework (BAF) to monitor the actions and assurance against the strategic risks and to assess the overall impact on delivery of NHS Devon and NHS Cornwall and Isles of Scilly's statutory / regulatory duties or corporate objectives and approve its submission to the South West Peninsula Board.

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10.10. The **Chief Executive Officer** (CEO) has overall responsibility for ensuring that an effective risk management system is in place. They are also responsible for ensuring an adequate system of internal control is in place.

The work of ensuring that this system is in place is delegated to the Company Secretary in practice, who is also responsible for overseeing the management and maintenance of the Board Assurance Framework (BAF) and ensuring the Board follows due process with regards to the overall management of risk. The Company Secretary is accountable to the CEO and is responsible for ensuring (and reporting to the South West Peninsula Board and to the Audit and Risk Committees meeting in common (ARC)) that systems and structures are in place for the effective management of financial risk and organisational controls.

10.11. The CEO is responsible for the Annual Governance Statement, setting out how these responsibilities have been discharged.

10.12. The **Chief Clinical Officer** is accountable to the CEO and is responsible for ensuring (and reporting to the Board or appropriately established committees) that systems and structures are in place for the effective management of clinical quality and safety.

10.13. The **Chief Clinical Officer** provides Clinical Leadership for NHS Devon and NHS Cornwall and Isles of Scilly and is accountable to the CEO and is responsible for providing strategic and operational leadership and management of the clinical risk within NHS Devon and NHS Cornwall and Isles of Scilly and organisational assurance on all matters of clinical risk and clinical outcomes to the South West Peninsula Board.

10.14. The **Chief Place and Transformation Officer** is the appointed **Caldicott Guardian** and ensures that the Caldicott principles for managing information and ensuring its security and integrity are adhered to by staff within NHS Devon and NHS Cornwall and Isles of Scilly.

10.15. The **Corporate Governance team** is responsible for overseeing the day-to-day management and co-ordination of the risk management system.

10.16. The allocated **Risk Manager** is responsible for providing support and advice on risk management issues NHS Devon and NHS Cornwall and Isles of Scilly. In addition, they will work closely with specialist advisers within NHS Devon and NHS Cornwall and Isles of Scilly who provide advice on specific areas of risk management, for example, Health and Safety; Fire; Infection Control; Manual Handling; Security; Fraud and Information Governance. The Risk Manager will provide information about corporate and strategic risks for to NHS Devon and NHS Cornwall and Isles of Scilly Chief Officers, Board Assurance Committees, and the South West Peninsula Board. This forms the basis of ‘bottom up’ population of the risk register and will be used to inform the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF). They are responsible for the ongoing development, implementation, and evaluation of risk management

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systems. These systems will align with the requirements of related regulatory bodies such as NHS England and the Care Quality Commission (CQC).

10.17. The Company Secretary, reporting to the CEO is responsible for ensuring the development and implementation of Risk Management Policy across NHS Devon and NHS Cornwall and Isles of Scilly, ensuring that risk management processes are effectively coordinated, implemented, and monitored. This responsibility includes:

- Maintenance and development of the Board Assurance Framework (BAF) and the NHS Devon and NHS Cornwall and Isles of Scilly Corporate Risk Register (CRR) as active documents through the implementation of appropriate mechanisms to enable clear monitoring of mitigation and action plans.
- Supporting the implementation of the NHS Devon and NHS Cornwall and Isles of Scilly Joint Policy on Risk Management (including the provision of advice and training).
- Overseeing and reporting on risk management compliance requirements.

10.18. The Company Secretary is also the appointed **Senior Information Risk Owner** (SIRO), accountable to the CEO and is responsible for managing information assets and risks across the organisations.

10.19. All **Chief Officers***, **Senior Leadership Team** members and **Operational Managers** are responsible for:

- Implementing the Joint Policy on Risk Management and procedures within their scope of responsibility.
- Ensuring that NHS Devon and NHS Cornwall and Isles of Scilly's risk management processes, including risk assessments, monitoring and escalation / de-escalation of cumulative risks and regular reviews are embedded in their team / programme management functions, included as a standing item on the monthly team meeting agenda and ensuring risk discussions are minuted or included in an action log.
- Ensuring that NHS Devon and NHS Cornwall and Isles of Scilly's risk management processes, including risk assessments, are in place within their scope of responsibility.
- Ensuring that relevant risks are identified, assessed, reviewed, and appropriately managed and escalated via RMG.
- Ensuring that they discuss risks with relevant senior managers and directors as appropriate.
- Implementing and monitoring any risk management actions within their designated area. When local actions are considered inadequate, senior managers are responsible for escalating these risks through RMG if local resolution cannot be satisfactorily achieved.

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- Reviewing a summary of all incidents within their teams or their scope of responsibility on a regular basis and disseminating this information to ensure that appropriate learning takes place in order to reduce risks.
- Ensuring that all staff are given the necessary information and training to enable them to be aware of the risks to their local objectives, those in their work environment and of their personal responsibilities and responsibilities towards working safely.
- Ensuring that staff undertake all relevant mandatory and RSET training.
- Ensuring staff compliance with this document.
- Having adequate knowledge of, and / or access to, all relevant legislation in order to ensure that compliance with such legislation is maintained.

* *It should be noted that a Chief Officer can delegate any of the responsibilities outlined above to their deputy but delegation below this level is not permitted. Where delegation is granted, this should be communicated by the Chief Officer in writing to the Corporate Governance team (and specifically the allocated Risk Manager).*

10.20. All **Staff** have a responsibility to co-operate with managers, and they are encouraged to identify risks and advise their line managers accordingly. Risk management is the responsibility of all employees. Key responsibilities include:

- Being familiar, and complying with, the Joint Policy on Risk Management and supporting procedures and with all other relevant policies and procedures.
- Reporting incidents, accidents and “near misses” following procedures set out in the Incident Reporting Policy and supporting procedures.
- Being aware of their duty under legislation to take reasonable care for personal safety and the safety of all others who may be affected by the business of NHS Devon and NHS Cornwall and Isles of Scilly.
- Complying with NHS Devon and NHS Cornwall and Isles of Scilly rules, regulations, and instructions to protect the health, safety, and welfare of anyone affected by the business of NHS Devon and NHS Cornwall and Isles of Scilly.

11. Impact Assessment

11.1. An Equality Quality Impact Assessment (EQIA) has been completed in respect of this policy. No concerns were highlighted.

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12. Monitoring Compliance and Effectiveness

Training

12.1. Risk Management training, although not currently part of the Mandatory Training requirement is considered as Role Specific Essential Training (RSET).

12.2. RSET can affect a small or large amount of staff. It may be defined by local risk or quality assessments, guidance from a professional body, regulatory guidance or other sources, such as workforce and business planning. It should not be seen as secondary to core Mandatory Training, but as an equal. Where a manager is unsure of a requirement, advice should be taken either from internal subject experts or from external bodies as appropriate.

12.3. Knowledge of how to manage risk is essential in embedding and maintaining an efficient risk management system. Risk management training is mandatory at induction and will form part of the annual review of staff development as part of an individual's annual appraisal review. The implementation of risk management by individuals will be performance managed through staffs' individual appraisal reviews. To this end, the Corporate Governance team will work in conjunction with Human Resources (HR) to conduct an annual Training Needs Analysis (TNA) to ensure that the necessary training and education needs, and methods needed to implement this policy, and any supporting procedure(s) are identified and resourced as required. This may include identifying external training providers and/or developing an internal training process.

12.4. The TNA and Risk Management Training Schedule will be reviewed and updated periodically so that it reflects the changing needs of the organisation and / or when there are significant changes in risk management arrangements (including changes to this policy or any of its related processes).

Implementation

12.5. Chief Officers, Directors and Managers, and/or their designated representatives, will implement this policy by:

- Notifying all staff of its existence. New staff will be informed of this policy as part of their induction and directed to the staff intranet to read the policy.

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- Discussing with staff as part of their regular one-to-ones how they seek to achieve their individual objectives around policy review and maintenance.
- All staff will be informed of the Policy's approval and subsequent changes via the Staff Bulletin, which will include a link to the document on the staff Intranet.

Review

12.6. NHS Devon and NHS Cornwall and Isles of Scilly will review its performance on risk management through a specific annual internal audit on Risk and Assurance Processes. This annual audit is submitted to the Audit and Risk Committees meeting in common (ARC) and is reflected in the Head of Internal Audit Opinion (HIAO) on the organisational arrangements for risk management and internal control.

12.7. The Chief Executive Officer (CEO) will review compliance with, and effectiveness of, the risk management system of internal control annually in preparing the Annual Governance Statement.

12.8. The ARC will review risk information submitted throughout the year. In addition, risk reports will be submitted to Board Assurance Committees as appropriate. These Committees can request information on specific risks to seek further assurance and details on actions being taken to address them.

12.9. NHS Devon and NHS Cornwall and Isles of Scilly Risk Appetite will be reviewed annually by the South West Peninsula Board.

12.10. Any trends resulting from possible policy non-compliance will be raised with staff through appropriate management routes.

12.11. Delivery and records of attendance at risk management awareness training will be reviewed annually by the Corporate Governance team.

12.12. This policy will be reviewed annually to ensure that it remains fit for purpose.

13. References

13.1. This policy does not stand alone and should be considered alongside the following related policies mentioned in this document. These are available on the staff intranet.

- Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy

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- Counter Fraud, Bribery, and Corruption Policy
- Internal Incident Policy
- Serious Incidents Policy
- EQIA Policy

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APPENDIX 1 - Glossary of Terms

Terms	Definition
Acceptance	Informed decision to take a particular risk.
Avoidance	Informed decision not to be involved in, or to withdraw from, an activity in order not to be exposed to a particular risk.
Consequence	Outcome of an event affecting objectives.
Control	Measure that is modifying risk. Control include any process, policy, device, practice, or other actions which may modify risk.
Governance	Is a system by which organisations are directed and controlled. It defines accountabilities, relationships and the distribution of rights and responsibilities among those who work with and in the organisation, determines the rules and procedures through which the organisation's objectives are set, and provides the means of attaining those objectives and monitoring performance. This includes the establishing, supporting, and overseeing the risk management framework.
Likelihood	Chance of something happening.
Monitoring	Continual checking, supervising, critically observing, or determining the status in order to identify change from the performance level or expected. Monitoring can be applied to a risk management framework, risk management process, risk, or control.
Reputational Risk	The adverse perception of the image of NHS Devon and NHS Cornwall and Isles of Scilly by patients, partner organisations and individuals, the local community or regulators.
Residual Risk	Risk remaining after risk treatment.
Resilience	Capacity of an organisation to adapt in a complex and changing environment.
Risk	Is the effect of uncertainty on objectives. Risk is usually expressed in terms of causes, potential events, and their consequences.
Risk Appetite	Amount and type of risk that an organisation is willing to pursue or retain.
Risk Assessment	

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Terms	Definition
	Overall process of risk identification, risk analysis and risk evaluation.
Risk Management	Is the co-ordinated activities designed and operated to manage risk and exercise internal control within an organisation.
Risk Management Process	Systematic application of management policies, procedures, and practices to the activities of communicating, consulting, establishing context, and identifying, analysing, evaluating, treating, monitoring, and reviewing risk.
Risk Matrix	Tool for ranking and displaying risks by defining ranges for likelihood and impact.
Risk Owner	Person with the accountability and to make a decision regarding the management of a risk.
Risk Profile	Description of any set of risks.
Risk Register	Record of information about identified risks. The term 'risk log' is sometimes used instead of 'risk register'.
Risk Reporting	Form of communication intended to inform particular internal or external stakeholders by providing information regarding the current state of risk and its management.
Risk Source	Element(s) which alone or in combination has the intrinsic potential to give rise to risk.
Stakeholder	Person or organisation that can affect, be affected by, or perceive themselves to be affected by a decision or activity.
Treatment	Process to modify risk. Risk treatment can involve: ▪ Avoiding the risk by deciding not to start or continue with the activity that gives risk to the risk; ▪ Taking or increasing the risk in order to pursue an opportunity; ▪ Removing the risk source; ▪ Changing the likelihood; ▪ Changing the impact; ▪ Sharing the risk with another party or parties (including contracts); and ▪ Retaining the risk by informed decision.

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Terms	Definition
	Risk treatments that deal with negative consequences are sometimes referred to as “risk mitigation”, “risk elimination”, “risk prevention” and “risk reduction”.

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APPENDIX 2 - Inherent and Residual Risk

NB: This is a procedural document separate to the Risk Management Policy and may be amended without requiring the amendment of the policy.

Event	Inherent Risk
<u>Event:</u> Getting into the driving seat of a car, turning on the engine and moving of off	<u>**Inherent Risk:**</u> Damage to vehicles and injury to driver, other road users and pedestrians
Risk Management Action	***Residual Risk***
▪ **Instructions to check mirrors and use indicators appropriately before moving off and to wear a seat belt**	▪ Reduced possibility of damage to vehicles and injury to driver, other road users and pedestrians
Further Risk Management Action	***Residual Risk***
▪ **Driver must obtain permission to move off from passenger who will ensure that mirrors are checked, indicator used appropriately, and seat belt is properly worn**	▪ Further reduced of the possibility of damage to vehicles and injury to driver, other road users and pedestrians
Further Risk Management Action	***Residual Risk***
▪ **In addition to the two measures above the car is immobilised, that is mechanically unable to move, until such a time as the passenger is satisfied that all safety precautions have been undertaken. The passenger will then flick a switch which will disengage the immobiliser**	▪ Even less possibility of damage to vehicles and injury to driver, other road users and pedestrians

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APPENDIX 3 - Risks and Issues

NB: This is a procedural document separate to the Risk Management Policy and may be amended without requiring the amendment of the policy.

The table below summarises the key differences between 'risks' and 'issues':

RISK	ISSUE
An event that may occur	An event that is **currently happening or has happened**
Described in the future tense	Described in the **present tense**
Has a material impact on objectives[1]	Has a material impact on objectives[1]
Can be beneficial or harmful / positive or negative	**Issue itself is always negative** *(however, the outcome of solving an issue may still be beneficial, albeit it may take more time and effort)*
Can be mitigated against to prevent the risk from becoming an issue	**Prevention is not possible**; action is needed to mitigate its impact or to resolve the issue
Management Techniques: **Reduce risk; transfer the risk; manage the risk; contingency plan; accept risk or terminate risk**	Management Techniques: **Problem solving; decision-making**

[1] *Material Impact on Objectives – this can be in terms of programme / project objectives, team objectives, directorate objectives, corporate objectives, or strategic objectives.*

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APPENDIX 4 - Risk Management Principles

NB: This is a procedural document separate to the Risk Management Policy and may be amended without requiring the amendment of the policy.

Principle	Principle Description
Proactive	Risk management will be used proactively to manage key risks and used as an active management tool. This helps to ensure that risks are considered, and future actions planned in a visible, consistent, and controlled manner. Risk management will form part of plans with work on risk management being front loaded.
Aligns with Objectives	Risk management will be focused on the key uncertainties which may impact on the achievement of one or more objectives. Risks will be identified and given the appropriate priority for action.
Fits the Context	The risk management approach will be designed to fit the internal and external environment in which NHS Devon and NHS Cornwall and Isles of Scilly operates and so that time, effort, resources, and energy will be used in the appropriate way.
Engages Partners and Stakeholders	Risk management will engage with the right partners and stakeholders in the Integrated Care System (ICS) and deal with different perceptions of risk. Appropriate risks will be identified early and dealt with at the right level.
Promotes, Guides and Supports a Clear and Consistent Approach	Risk management will provide clear and coherent guidance to staff and key stakeholders so everyone can see how NHS Devon and NHS Cornwall and Isles of Scilly identify, assess, and control key risks, and is consistent across the organisation. This enables people to compare results with plans and enable better decision making about how resources will be deployed. It also provides clear guidance on roles within risk management and explains responsibilities and accountabilities.
Informs Decision Making	Risk management will be linked to and inform decision making across the organisation. This enables important decisions to be made with explicit consideration of the impact of risks and the status of risk management. This also helps to safeguard the decision making process to allow for good decision making.
Facilitates Continual Improvement	Risk management will be used to help NHS Devon and NHS Cornwall and Isles of Scilly to improve by proactively managing risks and increasing organisational risk maturity. The organisation will use its experience of risk management to continually improve through 'lessons learned' and best use of the resources available.
Creates a Supportive Culture	NHS Devon and NHS Cornwall and Isles of Scilly will create a culture that recognises uncertainty and supports considered risk taking. The organisation recognises that zero risk taking is neither possible nor desirable.
Achieves Measurable Value	Risk management will help to achieve measurable value through the effective identification and management of key risks. In general, it costs less to anticipate and manage a risk than it does to recover from an issue.

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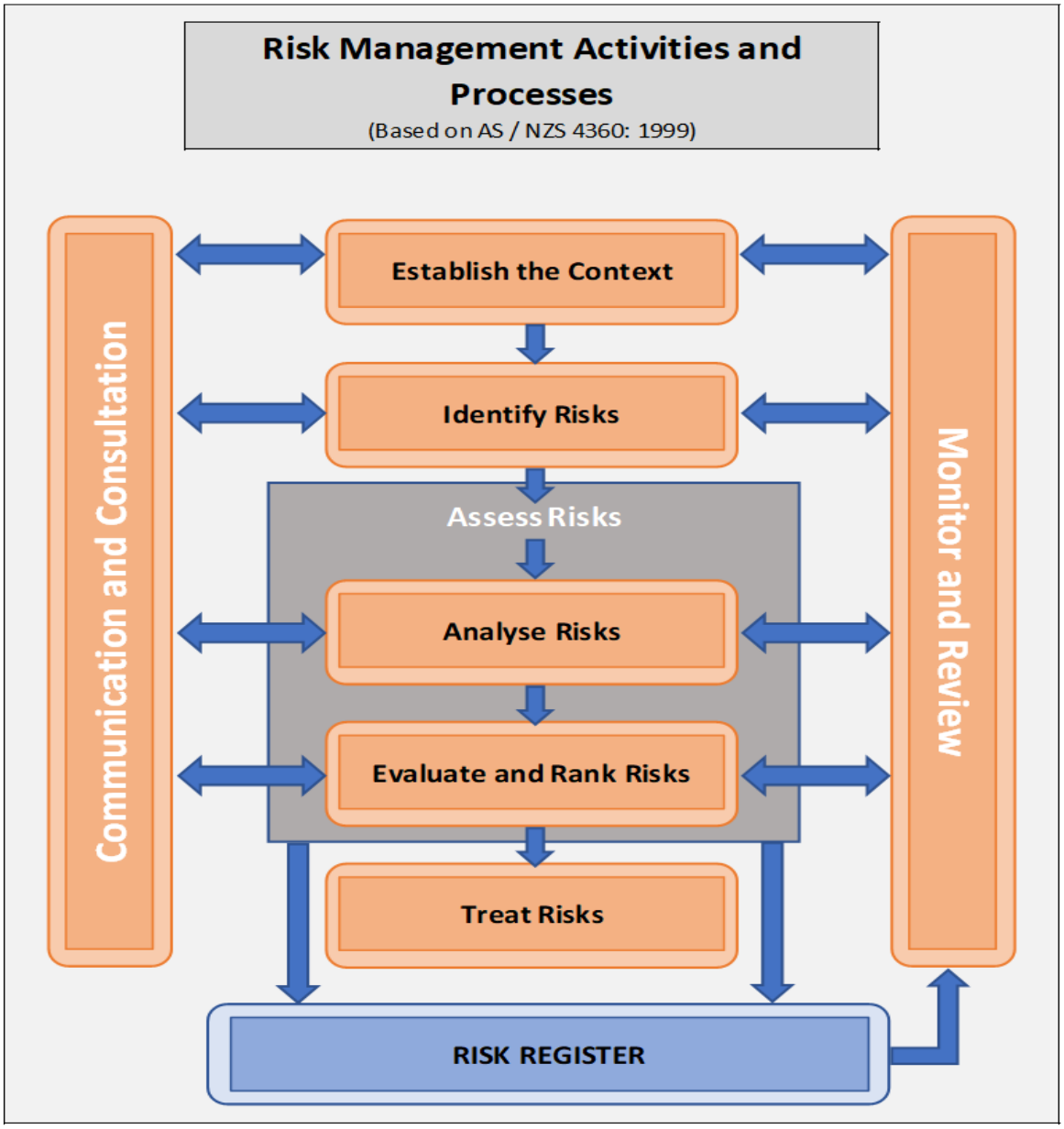
APPENDIX 5 - Risk Activities and Processes

NB: This is a procedural document separate to the Risk Management Policy and may be amended without requiring the amendment of the policy.

The following diagram sets out the NHS Devon and NHS Cornwall and Isles of Scilly approach to risk management:



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APPENDIX 6 - Model Risk Matrix

NB: This is a procedural document separate to the Risk Management Policy and may be amended without requiring the amendment of the policy.

Instructions for use:

1. Define the risk(s) explicitly in terms of the adverse impact(s) that might arise from the risk.

2. Use **Table 1** to determine the impact score (I) for the potential adverse outcome(s) relevant to the risk being evaluated. Choose the most appropriate domain for the identified risk from the left hand side of the table then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

3. Use **Table 2** to determine the likelihood score (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability, then use the probability descriptions to determine the most appropriate score.

4. Calculate the risk score by multiplying the impact by the likelihood: I (impact) x L (Likelihood) = R (risk score) - **See Table 3**.

5. Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings, the risk ratings and the organisations' risk management system. Include the risk in the organisations' risk register at the appropriate level.

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Table 1 – Impact (Consequences) - Scores

Impact (Consequence) Score (Severity Levels) and Examples of Descriptors					
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Patient Safety and Quality of Care Including capacity / resilience	Minimal injury, requires no / minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR / agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity / disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

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Impact (Consequence) Score (Severity Levels) and Examples of Descriptors					
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Clinical Effectiveness Including clinical incidents / reviews / complaints	Peripheral element of treatment or service suboptimal Informal complaint	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints / independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Inquest / ombudsman inquiry Gross failure to meet national standards
Workforce and Staff Wellbeing Includes Human Resources functions / Organisational Development / Staffing / Competencies	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory / key training	Uncertain delivery of key objective / service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory / key training	Non-delivery of key objective / service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis

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Impact (Consequence) Score (Severity Levels) and Examples of Descriptors					
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Regulatory and Legal Compliance Including Statutory Duty / Inspections	No or minimal impact or breach of guidance / statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations / improvement notice	Enforcement action. Multiple breaches in statutory duty. Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty. Prosecution Complete systems change required. Zero performance rating. Severely critical report
Publicity and stakeholder confidence Including reputational damage	Rumours Potential for public concern	Local media coverage – short- term reduction in public confidence	Local media coverage –long-term reduction in public confidence	National media coverage with service well below reasonable public expectation <3 days	National media coverage with service well below reasonable public expectation >3 days MPs concerned (questions in the House).
Business Objectives Including Project governance	Insignificant cost increase / schedule slippage	Elements of public expectation not being met. <5 per cent over project budget Schedule slippage <5 per cent	5–10 per cent over project budget Schedule slippage 5–10 per cent over	11–25 per cent over project budget Schedule slippage 11–25 per cent over Key objectives not met	Incident leading to >25 per cent over project budget Schedule slippage >25 per cent over Key objectives not met

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Impact (Consequence) Score (Severity Levels) and Examples of Descriptors					
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Financial and resource management Including Claims / Environmental Impact	Small loss Risk of claim remote Minimal or no impact on the environment	Loss of 0.1 – 0.25 per cent of budget Claim less than £10,000 Minor impact on environment	Loss of 0.26 – 0.5 per cent of budget Claim(s) between £10,000 and £100,000 Moderate impact on environment	Uncertain delivery of key objective / Loss of 0.6 – 1.0 per cent of budget Claim(s) between £100,001 and £1 million Purchasers failing to pay on time Major impact on environment	Non-delivery of key objective Loss of >1 per cent of Budget. Failure to meet specification / slippage. Payment by results Claim(s) >£1 million Catastrophic impact on environment
Information Governance and Cybersecurity Including Service / Business Interruption	Minor, unlikely unauthorised disclosure with no harm Minor data inaccuracies with no effect on care or operations Business loss / interruption of >1 hour	Limited unauthorised access affecting a small number of individuals, causing some concern Data errors causing minor workflow disruptions or delays in care Business loss / interruption of >8 hours	Unauthorised access to patient data causing distress Alteration of clinical or operational data impacting patient care or decision-making Business loss / interruption of >1 day	Large-scale data breach affecting many patients Corruption or manipulation of critical data leading to serious clinical errors or operational failures Business loss / interruption of >1 week	Severe breach causing widespread harm and legal penalties Systematic data tampering causing life-threatening clinical errors or widespread operational collapse Permanent loss of service or facility

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Table 2 - Likelihood Scores (L)

What is the likelihood of the risk occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood Score	1	2	3	4	5
Description	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency How often might it / does it happen	This will probably never happen / recur	Do not expect it to happen / recur but it is possible it may do so	Might happen / recur occasionally	Will probably happen / recur but it is not a persisting issue	Will undoubtedly happen / recur, possibly frequently

Table 3 - Risk Scoring = Impact x Likelihood (I x L)

Impact / Consequence	Likelihood				
	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 - Catastrophic	5	10	15	20	25
4 - Major	4	8	12	16	20
3 - Moderate	3	6	9	12	15
2 - Minor	2	4	6	8	10
1 - Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned as follows:

	1 to 6	**Low Risk**
	8 to 10	**Moderate Risk**
	12	**High Risk**
	15 to 25	**Extreme Risk**

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APPENDIX 7 - Risk Action and Reporting Requirements

NB: This is a procedural document separate to the Risk Management Policy and may be amended without requiring the amendment of the policy.

Score	Risk	Action	Reporting Requirements
1 to 6	Low	**Tolerate / Managed Through Normal Control Measures**	• Report to Line Manager. • Enter onto the local Team / Directorate Risk Register (TRR / DRR). • Managed by Local Manager and escalated to relevant Chief Officer (or delegated Deputy) as required.
8 to 10	Moderate	**Consider Treat / Review Control Measures**	
12	High	**Treatment Plans to be Developed, Implemented, and Monitored**	• Liaise with Corporate Governance team as appropriate to present to Risk Management Group. If approved, enter onto the Corporate Risk Register (CRR). • Included in Corporate Governance team's bi-monthly report to NHS Devon and NHS Cornwall and Isles of Scilly Chief Officers. • Oversight by NHS Devon and NHS Cornwall and Isles of Scilly Chief Officers through bi-monthly report from Corporate Governance team.
15 to 25	Extreme	**Immediate Action Required. Treatment Plans to be Developed, Implemented, and Monitored**	• Liaise with Corporate Governance team as appropriate to present to Risk Management Group. If approved, enter onto the Corporate Risk Register (CRR). • Included in the Corporate Governance team's Board Assurance Framework (BAF) reporting bi-monthly to NHS Devon and NHS Cornwall and Isles of Scilly Chief Officers. • Reported in Corporate Governance team's Board Assurance Framework (BAF) reporting to each meeting of the South West Peninsula Board

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Score	Risk	Action	Reporting Requirements
			and Committee-specific risks reported via Board Assurance Committees where appropriate.

In addition, the South West Peninsula Board receives the Board Assurance Framework (BAF) at each meeting with:

- Details of all of the strategic risks, their control measures, and assurances.
- Changes to the strategic risks since the previous report, including scoring.
- Current review narratives for each of the strategic risks.
- The level of assurance on each of the NHS Devon and NHS Cornwall and Isles of Scilly corporate objectives or Statutory Purposes in light of the risks which may impact on those objectives.
- Changes in the totality of risk facing NHS Devon and NHS Cornwall and Isles of Scilly (the total of the strategic level risks) and how this may have changed in the previous twelve months.

This process, its robustness and its deployment is scrutinised by the Audit and Risk Committees meeting in common (ARC). The Risk Management System is reviewed annually by Internal Auditors, and a report is provided to the Audit and Risk Committees meeting in common (ARC).

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APPENDIX 8 – Risk Appetite

NB: This is a procedural document separate to the Risk Management Policy and may be amended without requiring the amendment of the policy.

Risk appetite specifies the overall risk levels NHS Devon and NHS Cornwall and Isles of Scilly are willing to accept while operating in full compliance with regulatory and legal requirements. In addition, it establishes principles for risk taking to ensure that the totality of risk remains within the defined risk appetite boundaries.

The 'Risk Appetite' will be reviewed and agreed at least annually by the South West Peninsula Board.

The 'Risk Appetite' is framed around the priorities set out in the Risk Management Policy and the statement is agreed by the South West Peninsula Board annually. The statement is based on the premise that the lower the risk appetite, the less NHS Devon and NHS Cornwall and Isles of Scilly are willing to accept in terms of risk and consequently the higher levels of controls that must be in place to manage the risk.

Risk Theme	Risk Appetite Statement	Risk Appetite	Tolerance Level for Residual Risk
Safety failures in commissioned services	The Board has a **low** appetite for risk in relation to safety failures within commissioned services. Our primary focus is the elimination of avoidable harm and the maintenance of a robust culture of clinical safety. We prioritize compliance with national safety standards and regulatory requirements	Low	**6-10**
Quality failures in commissioned services	The Board has a **moderate** appetite for risks in relation to quality failures within commissioned services. We are receptive to innovative service models and transformation programmes that aim to improve long-term clinical outcomes, acknowledging that such changes may carry a degree of short-term delivery risk or temporary variability in quality metrics.	Moderate	**11-15**

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Risk Theme	Risk Appetite Statement	Risk Appetite	Tolerance Level for Residual Risk
System financial sustainability	The Board has a **low** appetite for risks that could jeopardise the long-term financial sustainability of the ICS. We prioritize the delivery of a balanced budget and adherence to statutory financial duties over the pursuit of innovative but high-risk financial ventures.	Low	**6-10**
Delivery of constitutional standards and recovery priorities	The Board has a **moderate** appetite for risks associated with the delivery of constitutional standards and recovery priorities. We are receptive to innovative delivery models and transformative changes that may cause short-term operational disruption or require temporary trade-offs in performance, provided these actions are essential to securing long-term service sustainability and improved patient outcomes. While we accept a degree of inherent risk in these pursuits, all such activities must be managed within a controlled environment with robust performance oversight to ensure no significant or lasting detriment to patient safety or core clinical quality	Moderate	**11-15**
Workforce sustainability and leadership resilience	The Board has a **moderate** appetite for risks associated with workforce sustainability and leadership resilience. We recognise that maintaining the 'status quo' is a significant risk in itself; therefore, we are willing to accept calculated risks to transform our workforce models and leadership structures.	Moderate	**11-15**
Failure to reduce health inequalities	The Board has a **moderate** appetite for risks associated with our duty to reduce health inequalities. We recognise that traditional, 'one-size-fits-all' service models have failed to close the equity gap; therefore, we are willing to take calculated risks to pilot unconventional, targeted interventions for our most underserved populations.	Moderate	**11-15**
Digital, data and analytics capability (incl	The Board has a **low** appetite for risks that could compromise our cyber security posture, the integrity of our data assets, or our compliance	Low	**6-10**

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Risk Theme	Risk Appetite Statement	Risk Appetite	Tolerance Level for Residual Risk
cyber security and information governance)	with IG and Data Protection legislation. Our primary objective is to maintain a secure, stable, and resilient digital environment.		
Provider and system alignment	The Board has a **moderate** appetite for risks associated with provider alignment and system integration. We recognise that achieving a 'one system' approach requires moving beyond traditional organisational boundaries; therefore, we are willing to accept calculated risks in the delegation of functions and the pooling of resources	Moderate	**11-15**
Reconfiguration and service change	The Board has a **high** appetite for risks associated with large-scale service reconfiguration and system-wide transformation. We believe that incremental change is no longer sufficient to meet the needs of our population; therefore, we are proactively seeking opportunities to fundamentally redesign how and where care is delivered	High	**16-20**

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APPENDIX 9 – External references

Legislation and statutory requirements

- Equality Act 2010
- Freedom of Information Act 2000
- Health and Safety at Work Act 1974
- Human Rights Act 1998
- Management of Health and Safety at Work Regulations 1999

Best practice recommendations and other key guidance

- Caldicott Principles
- Department of Health and Social Care Group Accounting Manual 2021/22
- Good Governance Institute - The New Good Governance Handbook 2016
- Federation of European Risk Management Associations (FERMA):
- Financial Reporting Council "UK Corporate Governance Code 2018"
- Health and Safety Executive 'Managing for Health and Safety 2013'
- The Institute of Risk Management 'A Risk Management Standard 2002'
- International Organisation for Standardisation (ISO) Guide '73:2009 Risk Management' (Revised 2016):
- NHS England - Learning from patient safety events
- NHS Resolution
- NHS Leadership Academy – The Healthy NHS Board 2013
- HM Government: The Orange Book – Management of Risk – Principles and Concepts:
- ISO 31000:2018 Risk Management Guidelines:
- NHS England Risk Management Framework (June 2025)

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Joint Policy on the Receipt, Acceptance and Management of Petitions

NHS Devon
NHS Cornwall and Isles of Scilly

Document Reference	**Policy on the Receipt, Acceptance and Management of Petitions**
Version	V1
Senior Responsible Officer	Company Secretary
Author/s	Head of Corporate Governance
Approved by	NHS Devon Integrated Care Board NHS Cornwall and Isles of Scilly Integrated Care Board
Date Approved	28 May 2026
Date Issued	1 June 2026
Date of next Review	31/03/2027

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Equality, diversity and inclusion statement

NHS Devon and NHS Cornwall and Isles of Scilly are committed to promoting equal opportunities, addressing health inequalities, and fostering good relations between people protected under the Equality Act 2010, the Health and Social Care Act 2012, and Human Rights legislation. We are equally committed to eliminating unlawful discrimination, harassment, and victimisation. To demonstrate this commitment, we develop, promote and maintain policies, strategies and operating procedures. Every effort is made to ensure that patients, employees, contractors or visitors do not experience discrimination; either directly or indirectly, because of their vulnerability; disadvantage; age, disability; gender reassignment; marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex (gender) or sexual orientation.

All staff must comply with this policy. Compliance must reflect our organisational commitment to and policy on equality, diversity and inclusion. In addition, each manager and member of staff involved in implementing this policy must give due regard to the needs of those protected under law.

If you, or any other groups, believe you are discriminated against under the terms of the Equality Act, the Health and Social Care Act 2012 or Human Rights legislation by anything contained in this document; or you need this document in an alternative format, for example, large print, Braille, Easy read or other languages; please contact our Patient Advice and Complaints Team (PACT):

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Policy Summary

Summary & Key Aims	Target Audience
Aim: To provide a voice for the local community, visibility to genuine concerns and ensure petitions are addressed appropriately. **Purpose:** Provide clear guidance on receiving, validating, and managing petitions to ensure consistent and fair handling across ICBs, whether in hard copy or e-petition.	All ICB staff, including Board Members, involved in policy-making processes, whether permanent, temporary, or contracted for services, whether as individuals or through third-party suppliers.
Key Requirements	**Previous Policy Names**
Petitions received in response to a formal consultation on a proposal to change an existing service will be managed through that process. Petitions may be submitted in paper or electronic format and will relate directly to: • services provided and decisions made by the ICBs or one of their partner organisations (where the service has been commissioned by one of the ICBs), or • a perceived gap in service provision or clinical policy. Share petitions with the Corporate Governance Team within 24 to 48 hours to ensure a response within policy timescales.	This Policy supersedes the individual policies of NHS Cornwall and Isles of Scilly and NHS Devon of the same name.
Risks to the ICB if the policy isn't followed	**What could happen if staff don't follow the policy**
Failure to adhere to this policy may result in petitions being deemed non-compliant and not formally accepted, which could lead to public dissatisfaction and loss of trust in the ICB's processes.	A complaint or formal grievance may be raised against the staff member by an aggrieved individual who has submitted a petition

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Table of Contents

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1. Introduction

1.1. The NHS Devon and NHS Cornwall and Isles of Scilly Integrated Care Board (ICB) Constitutions state that where a valid petition is received, it shall be included as an item for the agenda of the next meeting of the Board.

1.2. A petition represents the expression of the views of the people who sign it. For NHS Devon and NHS Cornwall and Isles of Scilly petitions are an important mechanism for local people to have a voice on local health matters.

1.3. Petitions can be raised as a discrete statement by the signatories or as a response to a public consultation or proposal being made by NHS Devon and NHS Cornwall and Isles of Scilly. To ensure that voices are heard appropriately and to avoid only listening to active lobby groups, NHS Devon and NHS Cornwall and Isles of Scilly will not view petitions in isolation, but as one piece of evidence and information which contributes to an overall picture of public opinion.

2. Purpose

2.1. The aim of this policy is to outline how NHS Devon and NHS Cornwall and Isles of Scilly will handle any petitions received from the local community.

3. Scope

3.1. This policy applies to the receipt, acceptance, and management of all petitions received by NHS Devon and NHS Cornwall and Isles of Scilly, whether in hard copy or as an e-petition. It does not apply to petitions received in response to a formal consultation on a proposal to change an existing service. These petitions will instead be managed through the formal consultation process.

4. Context

4.1. Petitions may be proactive, e.g., unsolicited, when public opinion indicates that a new service may be required to fill a perceived gap in service provision; or reactive, e.g., in response to an NHS-initiated proposal to change an existing service or clinical policy.

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4.2. There is currently no legally binding guidance to the NHS on handling petitions.

4.3. When considering the receipt and management of petitions, NHS Devon and NHS Cornwall and Isles of Scilly follow best practice and have drawn on published terms and conditions for submitting e-petitions used by HM Government.

4.4. This policy applies to all staff, including Board Members, involved in policy-making processes, whether permanent, temporary, or contracted for services (either as individuals or through third-party suppliers).

Criteria for the consideration of petitions

4.5. In order to be received by NHS Devon and NHS Cornwall and Isles of Scilly for consideration, petitions should meet the criteria outlined below:

- Petitions will relate directly to:
  - services provided and decisions made by the ICBs or one of their partner organisations (where the service has been commissioned by one of the ICBs);
  - or where there is a perceived gap in service provision or clinical policy.

- Petitions may be received in paper or electronic (e.g., email, web based or social media) format.

- Petitions should include a statement of petition which should include:
  - the organisation to which the petition is being addressed
  - the proposition which is being promoted by the petition
  - the timeframe over which the petition has been collected
  - the number of signatures collected

- The following information about each petitioner should be included:
  - Name
  - Postcode
  - Signature (in the case of a written petition)
  - Email address (in the case of an electronic petition). If this data is not collected due to the data controller not sharing the data e.g., a social media (e.g., Facebook) or 38 degrees petition, the petition will only be acknowledged as an indicator of public sentiment.

- The name and address of the petition organiser, who must be resident within the area to which the petition relates, should be provided on the first page of the petition.

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4.6. A petition amounting to any number of signatures will be considered by NHS Devon and NHS Cornwall and Isles of Scilly.

4.7. Only those with more than 1000 signatures will be presented to the South West Peninsula Board. For those petitions with fewer than 1000 signatures, the petition will be forwarded to the most appropriate Chief Officer for consideration and response.

4.8. Where a petition, with significant support (with a minimum of 1000 signatures) has been received by NHS Devon and NHS Cornwall and Isles of Scilly and meets the criteria above, the Chief Executive shall consult with the Chair as to how best to address the receipt of the petition at the next meeting of the South West Peninsula Board. This could be as a specific item for the agenda, as a reference in either the Chair or Chief Executive's Report to the Board. The purpose of presenting the petition is to enable the Board to be aware of the issues raised and the proposed actions to be taken in response.

Acceptance of Petitions

4.9. If staff receive a petition, they must share it with the Corporate Governance team within 24 to 48 hours. The lead petitioner will receive an acknowledgement of receipt within 5 working days, along with a clear explanation of the next steps which will include an assessment as to whether the petition meets the requirements of this policy.

4.10. Petitions will not be considered if they are repeated, focus on individual grievances, are in respect of a subject of persistent contact with the NHS Devon or NHS Cornwall and Isles of Scilly, or if they concern issues which are outside the ICBs' remit such as health issues of national concern. Petitions will also not be considered if the information contained is confidential, libellous, false, defamatory or offensive.

4.11. A petition will be considered as a repeat petition if:

a) it covers the same or substantially similar subject matter to another petition received within the previous six months;
b) it is presented by the same or similar individuals or groups as another petition received within the previous six months.

4.12. A petition will be considered as the subject of persistent contact if:

a) it focuses on individual grievances
b) it focuses on the actions or decisions of an individual and not the organisation

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c) the subject matter or individual submitting the petitions meets any of the definitions contained within the ICB 's "Dealing with Persistent and Unreasonable Members of the Public Policy".

4.13. A petition will be considered as outside the ICBs' remit if:
a) it focuses on a matter relevant to another organisation
b) it focuses on a matter of national rather than local concern
c) it requests information available via Freedom of Information legislation
d) its aim is to correspond on personal issue(s) with an individual(s)
e) signatories are not based in the UK

4.14. A petition will be considered as confidential, libellous, false or defamatory if:
a) it contains information which may be protected by an injunction or court order
b) it contains material which is potentially confidential, commercially sensitive, or which may cause personal distress or loss

4.15. A petition will be considered as offensive if:
a) it contains language that may cause offence, is provocative or extreme in its views

4.16. The petition's concerns will be assessed in relation to the aims being put forward, and the rationale and constraints behind it. For example, a petition proposing a realistic alternative will normally be given greater weight than one that simply opposes a validly put-forward option.

4.17. The petition's concerns will also be assessed in relation to the impact on other populations if these demands were accepted. This assessment could consider the views expressed in other petitions (which may conflict) or in more direct responses to the consultation.

4.18. Where a petition does not meet the requirements set out in the criteria above, NHS Devon and NHS Cornwall and Isles of Scilly will write to the petitioner within ten working days following the acknowledgement of receipt to confirm this, and the reason for rejection will be given clearly and explicitly. Should a petition relate to an individual grievance or treatment received by an individual, it will be referred to the Patient Experience Team for review and, if required, action via the NHS Complaints procedure

4.19. Any suspicion of fraud or bribery should be reported at the earliest available opportunity by contacting the Counter Fraud Specialist.

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Management of Petitions

4.20. The Corporate Governance team will evaluate all petitions to ensure compliance with the policy requirements.

4.21. A register of petitions received will be maintained by the Corporate Governance Team and reported annually to the Audit and Risk Committee.

4.22. Hard copy and electronic petitions will be stored in the Governance cupboard in the Board Room on S:\Governance & Data Protection\Governance\11. Governance - Other\02. Petitions respectively or 3 years from the date of receipt by NHS Devon and NHS Cornwall and Isles of Scilly will then be destroyed as confidential waste (in the case of hard copies) or deleted (e-petitions).

5. Accountabilities, Duties and Responsibilities

Chief Executive Officer	The Chief Executive has ultimate accountability for the strategic direction and operational management of NHS Devon and NHS Cornwall and Isles of Scilly, including compliance with all legal, statutory and policy requirements. The Chief Executive Officer is responsible for receiving petitions submitted to NHS Devon and NHS Cornwall and Isles of Scilly. Where petitions include over 1000 signatures, the Chief Executive Officer has the responsibility, together with the Chair, to consider and discuss at a meeting of the South West Peninsula Board any appropriate actions. The Chief Executive is responsible for ensuring that appropriate correspondence is sent to petitioners informing them of any rejected petitions and providing clear and explicit reasons for the rejection.
Chair	The Chair is responsible for reviewing petitions with over 1000 signatures together with the Chief Executive Officer for consideration to discuss at a meeting of the South West Peninsula Board to agree any appropriate actions.
Corporate Governance team	The Corporate Governance team is responsible for providing administrative support for the petition acknowledgement process.

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Managers	Senior Managers, or their designated representatives, are responsible for notifying all staff of the policy's existence. New staff will be informed of this policy as part of their induction Having adequate knowledge of, and / or access to, all relevant legislation in order to ensure that compliance with such legislation is maintained.
All Staff	Employed or engaged staff have a duty to ensure that any petitions received are shared with the Corporate Governance Team within 24 to 48 hours to allow a response within the timescales set out within this policy.

6. Impact assessments

6.1. An Equality Quality Impact Assessment (EQIA) has been completed in respect of this policy. No concerns were highlighted.

7. Implementation

7.1. Staff will be informed of the approval of the Policy via the Staff Bulletin, which will provide a link to the document on the Intranet.

7.2. This policy is subject to approval of the NHS Devon and NHS Cornwall and Isles of Scilly Integrated Care Boards following recommendation from the Audit & Risk Committees meeting in common.

8. Monitoring compliance and effectiveness

8.1. The Corporate Governance team will evaluate all petitions to ensure the policy requirements are met.

8.2. Petitions deemed to be non-compliant will not be formally accepted by the South West Peninsula Board. However, they will be listed as "other correspondence received" on the appropriate committee (or local council) agenda, if applicable.

8.3. Any suspicion of fraud or bribery should be reported at the earliest available opportunity by contacting the Counter Fraud Specialist.

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8.4. The log of petitions received, along with any policy-related breaches, will be reported annually to the Audit and Risk Committees meeting in common.

9. Review

9.1. This policy will be reviewed annually or sooner in the event of changes to legislation, national guidance or the local context.

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Audit and Risk Committee

Terms of Reference

Document Reference	Audit and Risk Committee Terms of Reference
Version:	V2.1
Senior Responsible Officer	Company Secretary
Author/S	Head of Corporate Governance
Approved by:	NHS Devon Integrated Care Board
Date Approved	28 May 2026
Date issued:	1 June 2026
Next Review date:	By 31 March 2027

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Audit and Risk Committee Terms of Reference

1. Constitution

1.1. The Audit and Risk Committee (the Committee) is established by the NHS Devon Integrated Care Board (ICB) as a committee of the Board in accordance with its Constitution, Standing Orders (SOs), and Scheme of Reservation and Delegation (SoRD).

1.2. These terms of reference (ToR), which must be published on the ICB website, set out the Committee's membership, remit, responsibilities, and reporting arrangements 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 Constitution, SOs, the SoRD, and other policies of the ICB.

1.4. The Committee is authorised to:

- Investigate any activity within its ToR;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee), within its remit as outlined in these ToR;
- Commission any reports it considers 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 decide the membership and ToR of any such task and finish sub-groups in line with the ICB's Constitution, SOs and SoRD, but may not delegate any decisions to such groups.

2. Purpose

2.1. The purposed of the Committee is to contribute to the overall delivery of the ICB's objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the organisation.

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2.2. The duties of the Committee will be driven by the Board's objectives and associated risks. An annual programme of business will be agreed at the start of each financial year; however, this programme of business will be flexible to new

and emerging priorities and risks

2.3. The Committee has no executive powers, other than those specified in these ToR.

3. Responsibilities

1. The Committee's duties are outlined below.

3.2. Integrated governance, risk management and internal control

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

3.2.2. To ensure that financial systems and governance are established which facilitate compliance with Department of Health and Social Care's (DHSC's) Group Accounting Manual (GAM).

3.2.3. To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the Board's objectives, and the effectiveness of the management of principal risks, including the receiving the Board Assurance Framework and Corporate Risk Register for review.

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

3.2.5. To ensure the ICB acts consistently with the principles and guidance established in His Majesty's Treasury's (HMT's) Managing Public Money.

3.2.6. 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.

3.2.7. To identify opportunities to improve governance, risk management and internal control processes across the ICB.

3.3. Internal audit

3.3.1. To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:

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3.3.1.1. Considering the provision of the internal audit service and the costs involved;
3.3.1.2. Reviewing and approving the annual internal audit plan and

more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;

3.3.1.3. Receiving a regular progress report on the implementation of the internal audit plan;

3.3.1.4. Considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources;

3.3.1.5. Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organization; and

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

3.4. <u>External audit</u>

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

3.4.1.1. considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit;

3.4.1.2. discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;

3.4.1.3. discussing with the external auditors their evaluation of audit risks and assessment of the organisation, and the impact on the audit fee; and

3.4.1.4. reviewing all external audit reports, including 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.

3.5. <u>Other assurance functions</u>

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

3.5.2. To review the work of other Committees in the ICB, whose work can provide relevant assurance to the audit and risk Committee's own areas of responsibility.

3.5.3. To assure the ICB that internal governance processes are fit for purpose for the purposes of maintaining a sound system of internal control and are operating effectively, through both management assurance annually, ahead of the annual governance statement sign-off and Internal Audit assessment (annual).

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3.5.4. To review the assurance processes in place in relation to financial and performance across the ICB, including the completeness and accuracy

of information provided.

3.5.5. To review the findings of external bodies and consider the implications for governance of the ICB. These will include, but will not be limited to:

3.5.5.1. reviews and reports issued by arm's length bodies or regulators and inspectors (for example, National Audit Office, Select Committee s, NHS Resolution, CQC)
3.5.5.2. reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies)
3.5.5.3. reviews and reports relating to governance and board effectiveness that are periodically commissioned by the ICB

3.5.6. To review the annual governance and compliance arrangements (including joint commissioning arrangements).

3.5.7. To receive annually a log of petitions received alongside any policy breaches.

3.6. Counter fraud

3.6.1. To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.

3.6.2. To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

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

3.6.4. To be responsible for ensuring that the counter fraud service submits an annual report and self-review assessment, outlining key work undertaken during each financial year to meet the NHS Standards for Commissioners: Fraud, Bribery and Corruption.

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

3.7. Freedom to speak up

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

appropriate follow-up action.

3.8. Emergency planning, resilience and recovery

3.8.1. To undertake a scrutiny and independent assurance oversight role in relation to the effectiveness of the systems and processes in place within the ICB in relation to emergency planning, resilience, and recovery (EPRR), including risk assessments, action plans and tests, to ensure the ICB fulfils its category 1 responder statutory requirements.

3.9. Information Governance (IG)

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

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

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

3.9.4. To provide assurance to the board that there is an effective framework in place for the management of risks associated with IG.

3.10. Financial reporting

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

3.10.2. To ensure that the systems for financial reporting to the board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

3.10.3. To review the annual report and financial statements (including accounting policies) before submission to the board, focusing particularly on:

3.10.3.1. the wording in the governance statement and other disclosures relevant to the terms of reference of the Committee
3.10.3.2. changes in accounting policies, practices and estimation techniques
3.10.3.3. unadjusted misstatements in the financial statements
3.10.3.4. significant judgements and estimates made in preparing of the financial statements
3.10.3.5. significant adjustments resulting from the audit
3.10.3.6. letter of representation
3.10.3.7. qualitative aspects of financial reporting

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3.11. *Conflicts of interest*

3.11.1. The Chair of the Audit and Risk Committee will serve as the nominated conflicts-of-interest guardian.

3.11.2. The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts (including gifts and hospitality and bribery) are effective, including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

3.12. *Management*

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

3.12.2. The Committee may also request specific reports from individual functions within the ICB, as appropriate to the overall arrangements.

3.12.3. To receive reports of breaches of policy and normal procedure or proceedings, including suspensions of the ICB's standing orders or retrospective approvals of expenditure, to provide assurance in relation to the appropriateness of decisions and to derive future learning.

4. Membership

4.1. Members of the Committee shall be appointed by the Board in accordance with the Constitution.

Chair & Vice Chair

4.2. In line with the Constitution, the Committee will be chaired by a Non-Executive Member of the Board appointed for their specific knowledge, skills and experience, making them suitable to chair the Committee.

4.3. The Committee Chair shall be independent and therefore may not chair any other Committees. To the extent possible, they will not serve on any other Board Assurance Committee.

4.4. Committee members may appoint a Vice Chair, who should be an Non-Executive Member of the Board with the requisite skills and experience to serve in that capacity.

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

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Membership

4.6. The membership of the Committee shall be constituted as follows:

- Non-Executive Member (Chair)
- Non-Executive Member
- Non-Executive Member

4.7. Neither the Chair of the Board nor employees of ICB will be members of the Committee.

4.8. Members will collectively possess knowledge, skills, and experience in accounting, risk management, internal and external audit, and technical or specialist issues pertinent to the ICB's business.

4.9. Members of the Committee need not be members of the Board, but they may be.

4.10. When determining the membership of the Committee , active consideration will be given to diversity and equality.

Attendees

4.11. Only members of the Committee have the right to attend Committee meetings however, all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- Chief Finance Officer
- Company Secretary,
- Representatives of both internal and external audit
- Individuals who lead counter fraud matters

4.12. Other individuals may be invited to attend all or part of any meeting as and when the Committee Chair considers they have expertise relevant to the Committee's responsibilities, including representatives from the health and wellbeing board(s), secondary and community providers

4.13. The Cluster Chief Executive Officer should be invited to attend the Committee at least annually.

4.14. The Cluster Chair may also be invited to attend one meeting each year to gain an understanding of the Committee's operations.

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

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Attendance

4.16. Members of the Committee may participate in meetings by telephone, video, or other electronic means, provided they are available and with the prior agreement of the Chair of the Committee. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are expected to attend at least 75% of meetings each year.

Access

4.17. Regardless of attendance, External Auditors, Internal Auditors, Local Counter-Fraud Auditors, and Security Management providers will have full and unrestricted access to the Committee.

5. Meetings, Quoracy, Decisions and Voting

Quorum

5.1. For a meeting to be quorate a minimum of 50% members (i.e. 2 non-executive members) is required, including the chair or vice chair of the Committee (unless they are disqualified from participating on that item in the agenda, by reason of a declaration of conflicts of interest).

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

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

Decision making and voting

5.4. In line with SOs, it is expected that decisions will be reached by consensus. When this is not possible, the Chair of the Committee may call a vote, the process for which is set out below:

5.4.1. All members of the Committee who are present at the meeting will be eligible to cast one vote each. (attendees and observers do not have voting rights).

5.4.2. Absent members may not vote by proxy. Absence is defined as not being present at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so.

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

5.4.4. If an equal number of votes are cast for and against a resolution, then the Chair of the Committee (or, in their absence, the Vice Chair) will have a second and casting vote.

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

5.5. For urgent decisions, the Chair of the Committee may call a meeting with notice of 2 days, setting out the reason for the urgency and the decision to be taken.

5.6. When an urgent matter arises that requires a decision outside the meeting (and cannot wait for the next scheduled meeting), the Chair of the Committee may make a decision after conferring with at least two other members ("Chair's Action").

5.7. When the Chair's Action has been taken, the next quorate meeting of the Committee must ratify it. Urgent decisions will only be taken when there is insufficient time available for the decision to be delayed until the next meeting.

6. Ways of Working

6.1. All 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 Constitution, its SOs, Standing Financial Instructions, and the Standards of Business Conduct Policy.

6.2. Members of the Committee must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change in inclusion, equality and diversity.

6.3. A Register of Interests will be reviewed at each Committee meeting. Those in attendance will be asked by the Chair of the Committee to declare any interests at the beginning of each meeting. If a member of the Committee feels compromised by any agenda item, they should declare a conflict of interest and agreement reached as agree on the action to be taken as set out in the Conflicts of Interest Policy.

7. Reporting Arrangements

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

7.2. The Chair will be responsible for ensuring that minutes of the meetings are formally recorded by the secretary and submitted to the South West Peninsula Board after each meeting on how it has discharged its responsibilities. The report shall be presented to the public meeting of the Board.

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7.3. The Chair of the Committee will provide an assurance report on behalf of the Committee to the South West Peninsula Board after each meeting, outlining

how it has discharged its responsibilities. The report shall be presented to the public meeting of the Board.

7.4. Where minutes and reports identify confidential matters, they will not be made public and will be presented at a private meeting of the Board.

7.5. The Committee shall undertake an annual self-assessment of its performance against its annual programme for business, membership, and ToR. The outcome of this self-assessment will be included in the Review of Corporate Governance reported to the Board on an annual basis.

7.6. The Committee will provide the Board with an annual report, timed to support the finalisation of the accounts and the governance statement. The report will summarise its conclusions from the work carried out during the year, specifically commenting on:

7.6.1. the fitness for purpose of the assurance framework;
7.6.2. the completeness and 'embeddedness' of risk management within the organization;
7.6.3. the integration of governance arrangements;
7.6.4. the appropriateness of the evidence demonstrating that the organisation is fulfilling its regulatory requirements; and
7.6.5. the robustness of the processes underpinning the quality accounts.

8. Meeting and Administration

Meetings

8.1. The Committee will meet in private at least four times a year. Additional meetings may take place as required.

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

8.3. The External Auditor, or Head of Internal Audit, may also request a meeting should they consider one necessary

8.4. At least once a year the Committee will meet privately with the external and internal auditors.

8.5. Arrangements and notice for calling meetings are set out in the SOs.

8.6. In line with the SOs, the Committee may meet virtually when necessary and members attending using electronic means will count towards the quorum.

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Administration

8.7. The Committee shall be supported by the Corporate Governance Team. Their duties in this respect will include:

8.7.1. Agreement of agendas with the Chair and attendees.
8.7.2. Preparation, collation and circulation of papers in good time.
8.7.3. Ensuring that those invited to each meeting attend, highlighting any concerns to the Chair (including interests of members that may conflict with an agenda item).
8.7.4. Taking the minutes and helping the Chair to prepare reports to the South West Peninsula Board.
8.7.5. Keeping a record of matters arising and issues to be carried forward.
8.7.6. Maintaining records of members' appointments and renewal dates.
8.7.7. Ensuring that action points are taken forward between meetings.
8.7.8. Ensuring that members receive the development and training they need.
8.7.9. Providing appropriate support to the Chair and members.

8.8. Following each meeting of the Committee, the administrator will maintain:

8.8.1. an attendance log and follow up as appropriate after each meeting to ensure the Committee adheres to the required frequency of attendance by members.
8.8.2. a decision log of reporting arrangements in each formal meeting of the Committee
8.8.3. a log of summary written reports provided to the South West Peninsula Board from formal meetings of the Committee.

9. Review

9.1. These ToR will be reviewed annually as part of the annual committee effectiveness review.

Change Record

Date	Version	Author	Status	Summary of Changes
2026-02-03	V2	J James/K Kingan	Draft	Harmonisation of text with NHS CIOS - Review and revise the Terms of Reference for NHS Cornwall & Isles of Scilly and NHS Devon to support collaborative working and lay the foundation for a future single entity. ToR reviewed against the NHSE Model Terms of Reference. ToR reviewed and revised to meet AIS.

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Remuneration Committee

Terms of Reference

Document Control

Doc Reference	RemCo ToR
Version:	V2.1
Senior Responsible Officer	Company Secretary
Author	Head of Corporate Governance
Approved by:	NHS Devon Integrated Care Board
Date Approved	28 May 2026
Date issued:	01 June 2026
Review date:	Before 31 March 2027

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Remuneration Committee
Terms of Reference

1. Constitution

1.1. The Remuneration Committee (the Committee), and its associated Non-Executive Member (NEM) Remuneration Panel, is established by NHS Devon (Devon) Integrated Care Board (ICB) as a Committee of the Board in accordance with its Constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD).

1.2. These Terms of Reference (ToR), including Annex A, which must be published on the ICB website, set out the membership, 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.

1.4. The Committee is authorised to:

a) decide on proposals and recommendations put to it within the powers delegated to it by the ICB and/or as detailed in these ToR;
b) investigate any activity within its ToR;
c) seek any information it requires within its remit from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these ToR;
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 or 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 ToR of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and SoRD, but may not delegate any decisions to such groups
f) ensure robust and effective discussion and focused management of the ICB's objectives
g) invite reports from partners and stakeholder committees (or groups) where this impacts on the functions of the ICB
h) establish a separate remuneration task and finish group to determine all aspects of remuneration, including but not limited to salary and other contractual terms and non-contractual terms, for the ICB's Non-Executive Members

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2. Purpose

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

- Confirm the ICB pay policy including adoption of any pay frameworks for all employees including senior managers/directors (including Board Members) and Non-Executive Members of the Board (excluding the Chair)

2.2. In respect of the Non-Executive Members of the ICB, this shall be carried out through the NEM Remuneration Panel. The remit of the Panel is set out in Annex A.

2.3. The Board has also delegated the following functions to the Committee:

- Oversight of Executive Board Member performance

2.4. The Committee has no executive powers, other than those delegated in the SoRD and specified in these ToR.

3. Responsibilities

3.1. The Committee's duties are outlined below.

3.2. For the Chief Executive, Chief Officers and other Very Senior Managers:

3.2.1. Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, fees or allowances
3.2.2. Approve provisions for other benefits, including pensions (and the NHS Pension Scheme), relocation and cars
3.2.3. Determine arrangements for termination of employment and other contractual terms and non-contractual terms
3.2.4. Asses proper calculation and scrutiny of termination payments taking account of such national guidance as appropriate, advising on and overseeing appropriate contractual arrangements for such staff
3.2.5. Approve any proposed redundancy, severance or settlement costs and payments, where necessary providing this in advance of any authorisation needed from NHS England and the Treasury
3.2.6. Asses proper calculation and scrutiny of any special payments
3.2.7. Functions in relation to performance review/ oversight for directors/senior managers undertaken by the Chief Executive or their nominated deputy
3.2.8. Consider and approve the annual review of the performance of the Chief Executive conducted by the Chair
3.2.9. Consider and approve the annual review of the performance of the executive directors conducted by the Chief Executive

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3.2.10. Succession planning for the Board
3.2.11. Approve changes to the director structure when reliance on the ICB's organisational change policy is required

3.3. For all staff:

3.3.1. Approve the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change)
3.3.2. Oversee contractual arrangements including those resulting from use of the ICB's organisational change policy
3.3.3. Approve the arrangements for termination payments/redundancies and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate
3.3.4. Approve any proposed redundancy, severance or settlement costs and payments, where necessary providing this in advance of any authorisation needed from NHS England and the Treasury

3.4. For other ICB Board Members:

3.4.1. Consider and approve the annual review of the performance of the ICB Partner Members conducted by the NHS Cornwall and Isles of Scilly and NHS Devon Cluster chair
3.4.2. Review the outcomes of the ICB Board performance evaluation process, including thematic outcomes from appraisals, that relate to the performance and effectiveness of the Board
3.4.3. Provide assurance regarding the policy and process for the appointment of Co-opted Members of Board Committees
3.4.4. Provide assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and Proper Person Regulation (FPPR) and conflicts of interest requirements.

4. Membership

4.1. Members of the Committee shall be appointed by the ICB Board in accordance with the Constitution.

Chair & Vice Chair

4.2. In accordance with the Constitution, the Committee will be chaired by a Non-Executive Member of the Board, appointed for their specific knowledge, skills and experience, making them suitable to chair the Committee.

4.3. Committee members may appoint a Vice Chair from among the members of the Committee, who must be a Non-Executive Member of the Board and possess the requisite skills and experience to act in that capacity.

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4.4. In the absence of the chair, or vice chair, the remaining members present shall elect one of their number to chair the meeting.

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

Membership

4.6. All Non-Executive Members (excluding the Chair of the Audit and Risk Committee) are members of the Committee. Non-Executive Members are unable to send a nominated representative to the meeting.

4.7. In line with provisions set out in the ICB Constitution:

- The NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chair may be a member of the Committee but may not be appointed as the chair.
- The Chair of the Audit and Risk Committee may not be a member of the Committee.

4.8. Members will possess between them the requisite knowledge, skills and experience pertinent to the Committee's ToR, calling on specialist advice when needed.

4.9. When determining the membership of the Committee, active consideration will be made to diversity and equality.

Attendees

4.10. Only members of the Committee have the right to attend Committee meetings, but the chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

4.11. Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees as listed below, as well as others invited by the chair for their expertise, will not be eligible to vote.

- Chair of the Audit and Risk Committee
- Chief Executive Officer
- Chief People Officer
- Company Secretary

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

4.13. No individual should be present during any discussion relating to:

- any aspect of their own pay
- any aspect of the pay of others when it has an impact on them

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Attendance

4.14. Members of the Committee may participate in meetings by telephone, video, or other electronic means where available and with the prior agreement of the chair of the committee. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are normally expected to attend at least 75% of meetings during the year.

5. Quorum, Decisions and Voting

Quorum

5.1. For a meeting to be quorate a minimum of 50% members (i.e., 3 members) is required, including the Chair or Vice Chair of the Committee (unless they are disqualified from participating on that item in the agenda, by reason of a declaration of conflicts of interest).

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

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

Decision making and voting

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

5.5. In line with Standing Orders, it is expected that decisions will be reached by consensus. When this is not possible, the chair may call a vote, the process for which is set out below:

5.5.1. All members of the Committee who are present at the meeting will be eligible to cast one vote each. (attendees and observers do not have voting rights).

5.5.2. Absent members may not vote by proxy. Absence is defined as not being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so.

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

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5.5.4. If an equal number of votes are cast for and against a resolution, then the chair of the Committee (or in their absence, the Vice Chair) will have a second and casting vote.

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

5.6. For urgent decisions, the chair of the Committee may call a meeting with notice of 2 days, setting out the reason for the urgency and the decision to be taken.

5.7. When an urgent matter arises that requires a decision outside the meeting (and cannot wait until the next scheduled meeting), the chair of the committee may make a decision after conferring with at least two other members ("Chair's Action").

5.8. When a Chair's Action has been taken then the next quorate meeting of the Committee must ratify it. Urgent decisions will only be taken when there is insufficient time available for the decision to be delayed until the next meeting

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6. Ways of Working

6.1. All 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 Constitution, its Standing Orders, Standing Financial Instructions, and the standards of business conduct policy.

6.2. Members of the Committee must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change in inclusion, equality and diversity.

6.3. 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.

6.4. A Register of Interests will be reviewed at each Committee meeting. Those in attendance will be asked by the Chair of the Committee to declare any interests at the beginning of each meeting. If a member of the Committee feels compromised by any agenda item, they should declare a conflict of interest and agreement reached as agree on the action to be taken as set out in the Conflicts of Interest Policy.

7. Reporting Arrangements

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

7.2. The Chair of the Committee will be responsible for ensuring that minutes of the meetings are formally recorded by the secretary and submitted to the South West Peninsula Board on behalf of the ICB Board in accordance with Standing Orders.

7.3. The Chair of the Committee will provide an assurance report on behalf of the Committee to the South West Peninsula Board after each meeting on how it has discharged its responsibilities. The report shall be presented to the public meeting whenever possible. Where minutes and reports identify individuals, they will not be made public and will be presented at a private meeting of the South West Peninsula Board. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

7.4. The Committee shall undertake an annual self-assessment of its own performance against its annual programme of business, membership and ToR. The outcome of this self-assessment will be included in the Review of Corporate Governance, reported to the Board annually.

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

8. Meetings and Administration

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

8.2. The South West Peninsula Board, Cluster Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

8.3. In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will count towards the quorum.

Administration

8.4. The Committee shall be supported by an administrator from within the Corporate Governance Team. Their duties in this respect will include:

8.4.1. Agreement of agendas with the Chair and attendees.
8.4.2. Preparation, collation and circulation of papers in good time.
8.4.3. Ensuring that those invited to each meeting attend, highlighting any concerns to Chair (including interests of members that may conflict with an agenda item).
8.4.4. Taking the minutes and helping the Chair to prepare reports to the South West Peninsula Board.
8.4.5. Keeping a record of matters arising and issues to be carried forward.
8.4.6. Maintaining records of members' appointments and renewal dates.

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8.4.7. Ensuring that action points are taken forward between meetings.
8.4.8. Ensuring that members receive the development and training they need.
8.4.9. Providing appropriate support to the Chair and members.

8.5. Following each meeting of the Committee, the administrator will maintain:

8.5.1. An attendance log and follow up as appropriate after each meeting to ensure the Committee adheres to the required frequency of attendance by members.
8.5.2. A decisions log of reporting arrangements into each formal meeting of the Committee.
8.5.3. A log of summary written reports provided to the South West Peninsula Board from formal meetings of the Committee.

9. Review

9.1. These Terms of Reference will be reviewed annually as part of the annual committee effectiveness review.

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Annex A
Non-Executive Member Remuneration Panel

Due to conflicts of interest, Non-Executive Members (NEMs) are unable to consider their own remuneration. To overcome this, the NEM Remuneration Panel (the Panel) which will operate under the principles and ethos contained within the Remuneration Committee's Terms of Reference.

The Panel will act in accordance with the ICB's Constitution and Standing Orders, as well as the delegations contained within the Scheme of Reservation and Delegation and Standing Financial Instructions. Despite the Panel's remit being an Annex to the Remuneration Committee's Terms of Reference, it is an independent group of the ICB with decision making capabilities.

The Panel shall meet at least annually to consider:

- NEM remuneration
- a summary of the annual performance reviews of NEMs conducted by the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chair

Proposals shall determine all aspects of remuneration, including, but not limited to, salary and other contractual and non-contractual terms, for NEMs, taking into account relevant national guidance available.

Its membership excludes NEMs, except for the Cluster Chair. Instead, the membership shall include:

- The Cluster Chair
- 2 Partner Members of the ICB Board
- A co-opted member appointed by the Cluster Chair

The following Cluster Officers shall attend the Panel to provide expertise and advice, taking account of any national guidance available:

- Chief People Officer
- Company Secretary

The Cluster Chief Executive may also attend.

Attendees shall not count towards quoracy.

The chair of the Panel shall be the Cluster Chair. The role of vice chair shall be held by one of the ICB Partner Members.

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When presenting the summary of annual NEM appraisals, the Cluster Chair shall hand over their chairing role to the vice chair and not count towards quoracy.

Quoracy will require 2 members which must include the Chair or an ICB Partner Member to be present.

Decisions on proposals will be reached by consensus. If this is not possible then members shall vote and the majority view will be carried. Where there is a split vote, with no clear majority, the chair of the Panel will hold the casting vote. In exceptional circumstances, where escalation is required following disagreement, this shall be to NHS England.

The Panel does not have responsibility for establishing the Cluster Chair's pay. This remains the responsibility of NHS England.

Decisions made by the Panel shall be reported to the public meeting of the South West Peninsula Board.

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Change Record

Date	Version	Author	Status	Summary of Changes
19.03.2026	V2	Company Secretary/ Head of Corporate Governance	Draft	Alignment with NHS CIOS Rem Committee ToR. Roles updated to reflect organisational changes. Review ToR and revised document to reflect AIS.

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South West Peninsula Board

Terms of Reference

1. Introduction and purpose

1.1. The South West Peninsula Board (the SWPB) has been established by NHS Cornwall and the Isles of Scilly Integrated Care Board and NHS Devon Integrated Care Board (the Partner ICBs) pursuant to sections 65Z5 and 65Z6 of the National Health Service Act 2006 as amended ('the NHS Act'). In accordance with Section 65Z5 of the NHS Act, Integrated Care Boards (ICBs) can establish and maintain joint working arrangements to jointly exercise their commissioning functions, with Section 65Z6 giving the power to establish a joint committee.

1.2. The purpose of the SWPB is to enable the Partner ICBs to enact their Cluster arrangement and take decisions as one in the best interests of the populations of Devon, Cornwall and the Isles of Scilly and fulfil the four core purposes of Integrated Care Systems (ICSs):

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

2. Responsibilities

2.1 The SWPB shall be responsible for the key decisions previously reserved to the Boards of both partners, except for those which cannot be delegated, as summarised below:

Statutory functions that cannot be delegated

2.1.1 Decision making in respect of NHS Continuing Healthcare and NHS funded nursing care functions
2.1.2 Annual accounts preparation and approval
2.1.3 Constitutional compliance matters specific to each ICB
2.1.4 Individual ICB statutory reporting requirements

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2.1.5 Functions that are required by NHS England to remain with individual ICBs
2.1.6 Such other functions as are determined to be non-delegable by an ICB

Corporate governance functions

2.1.7 Approval of changes to each ICB's Constitution
2.1.8 Approval of ICB Operational Scheme of Delegation
2.1.9 Approval of ICB Standing Financial Instructions

3. Membership

3.1 Members of the SWPB shall be appointed by the Partner ICBs and cannot be varied without the agreement of both the Partner ICBs' Boards.

Chair & Deputy Chair

3.2 The SWPB will be chaired by the single Chair of the Partner ICBs' Boards, as appointed by NHS England, with the approval of the Secretary of State for Health and Social Care (also known as the Cluster Chair).

3.3 The SWPB Chair will appoint a Deputy Chair from amongst the membership of the SWPB. This must be a Non-Executive Member of the Partner ICBs' Boards, who has the requisite skills and experience to act in that capacity.

3.4 The Chair of the SWPB will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference, in line with the Standing Orders of both Partner ICBs.

Membership

3.5 The membership of the SWPB shall be constituted as follows:

- Cluster Chair
- Non-Executive Members (x6)
- NHS Cornwall and Isles of Scilly: Partner Member – Providers of Primary Care Medical Services
- NHS Devon: Partner Member – Providers of Primary Medical Services
- NHS Cornwall and Isles of Scilly: Partner Member – NHS Providers
- NHS Cornwall and Isles of Scilly: Partner Member – NHS Providers (mental health)
- NHS Devon: Partner Member – NHS Trusts and Foundation Trusts
- NHS Cornwall and Isles of Scilly: Partner Member - Local Authorities
- NHS Devon: Partner Member – Local Authorities
- NHS Devon: Mental Health Member
- Cluster Chief Executive Officer
- Cluster Chief Officers (x6)

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- Chief Strategic Planning and Commissioning Officer
- Chief Place and Transformation Officer (Chief Medical Officer)
- Chief Population Health Officer
- Chief Clinical Officer (Chief Nursing Officer)
- Chief People Officer
- Chief Finance Officer

3.6 These individuals will all have voting rights as SWPB members.

Other participants

3.7 Only members of the SWPB have the right to attend and vote at SWPB meetings; however, meetings of the SWPB will also include the following participants who are not members:

- Director of Public Health, from one of Cornwall Council or Council for Isles of Scilly
- Director of Public Health, from one of Devon County Council, Plymouth City Council, or Torbay Council
- Representative of the VCSE within Cornwall and Isles of Scilly
- Representative of the VCSE within Devon
- GP Collaborative Board Chair, Cornwall and Isles of Scilly
- Devon GP Collaborative Board Chair
- Cluster Company Secretary

3.8 Other attendees may be invited to attend all or part of any meeting as and when the Chair of the SWPB considers they have expertise that would be relevant to the responsibilities of the SWPB.

3.9 The Chair of the SWPB 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.

Attendance

3.10 Members of the SWPB may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair of the SWPB. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are normally expected to attend at least 75% of meetings during the year.

Conflicts of Interest

3.11 Members' conflicts of interests to be held by their respective organisations and made available on organisations' websites.

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3.12 All potential conflicts of interest pertinent to agenda items must be declared and recorded at the start of each meeting.

4. Quorum, Decisions and Voting

Quorum

4.1. The quorum for meetings of the SWPB will be members, including:

a) Chair or Deputy Chair
b) At least two Executive Members
c) At least three Non-Executive Members
d) At least two of either the Partner Members or the Mental Health Member

4.2 If any member of the SWPB is unable to participate 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.

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

Decision Making and Voting

4.4. In line with the Standing Orders of each of the Partner ICBs, it is expected that decisions will be reached by consensus. Should this not be possible, each member of the SWPB will have one vote, the process for which is set out below:

a) All members of the SWPB who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the SWPB are set out at paragraph 3.5; attendees and observers do not have voting rights).

b) Absent members may not vote by proxy. Absence is defined as not being present at the time of the vote, but this does not preclude anyone attending via teleconference or other virtual means from exercising their right to vote if eligible.

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

d) If an equal number of votes are cast for and against a resolution, then the Chair of the SWPB (or in their absence, the Deputy Chair) will have a second and casting vote.

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

4.5 For urgent issues, the Chair of the SWPB may call a meeting at a notice of 5 days, setting out the reason for the urgency and the issue to be addressed.

5. Ways of Working

5.1 All members of the SWPB will have due regard to and operate within the Constitutions of the Partners, their Standing Orders, Standing Financial Instructions and other financial procedures.

5.2 Members of the SWPB will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

5.3 Members of the SWPB must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

5.4 A Register of Interests will be reviewed at each SWPB meeting. Those in attendance will be asked by the Chair of the SWPB to declare any interests at the beginning of each meeting. If a member of the SWPB feels compromised by any agenda item, they should declare a conflict of interest and agreement reached as the action to be taken as set out in the Partner ICBs' Conflicts of Interest Policy.

5.5 If necessary, the SWPB may draw on third-party support to assist it in resolving any disputes, such as peer review or support from NHS England.

6. Reporting Arrangements

6.1 The SWPB is accountable to the Partner ICBs' Boards and shall report to the Boards at least annually on how it discharges its responsibilities.

6.2 The SWPB shall undertake an annual self-assessment of its own performance against its annual programme of business, membership and Terms of Reference.

7. Meetings and Administration

Frequency of Meetings

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7.1 The SWPB will meet in public and in private every other month (except for August).

7.2 The SWPB will meet formally in private in the alternate months (except for August).

7.3 The Chair of the SWPB may ask the SWPB to convene further meetings to discuss particular issues they consider pertinent.

7.4 Arrangements and notice for calling meetings are set out in the Partner ICBs' Standing Orders.

7.5 Whilst in person attendance is expected at most meetings, when an urgent meeting is called members of the Committee may participate by telephone, video or by other electronic means where they are available and with the prior agreement of the Cluster Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.

Publication of notices, minutes and papers

7.6 The Chair of the SWPB shall see that a notice of any public meeting of the SWPB, together with an agenda listing the business to be conducted and supporting documentation, is published one week (or, in the case of a special meeting, two days) prior to the date of the meeting.

7.7 The proceedings and decisions taken by the SWPB shall be recorded in minutes, and those minutes circulated in draft form within two weeks of the date of the meeting. The SWPB shall confirm those minutes at its next meeting.

Administration

7.8 The SWPB shall be supported by an administrator from within the Partner ICBs' Corporate Governance team. Their duties in this respect will include:

a) Agreement of agendas with the Chair and attendees.
b) Preparation, collation and circulation of papers in good time.
c) Ensuring that those invited to each meeting attend, highlighting any concerns to Chair (including interests of members that may conflict with an agenda item).
d) Taking the minutes and helping the Chair to prepare any necessary reports to the Partners' Boards.
e) Keeping a record of matters arising and issues to be carried forward.
f) Maintaining records of members' appointments and renewal dates.
g) Ensuring that action points are taken forward between meetings.
h) Ensuring that members receive the development and training they need.
i) Providing appropriate support to the Chair and members.

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7.9 Following each meeting of the SWPB, the administrator will also:

a) Maintain an attendance log and follow up as appropriate after each meeting to ensure the SWPB adheres to the required frequency of attendance by members; and
b) Maintain a decisions log of reporting arrangements into each formal meeting of the SWPB.

8. Review of Terms of Reference

8.1 The Terms of Reference will be reviewed annually or earlier if required. Any proposed amendments will be submitted to the Partner ICBs' Boards for approval.

Document Control

Document Reference	SWPB ToR
Version	V1.1
Senior Responsible Officer	Philippa Harding, Company Secretary,
Author/s	Head of Corporate Governance
Approval by	NHS Devon Integrated Care Board NHS Cornwall and Isles of Scilly Integrated Care Board
Date last reviewed/ approved	28 May 2026
Next review date	By 31 March 2027

Change Record

Date	Version	Comments
19.03.26	V1.1	Annual Committee Review. Document Control template amended. Membership Updated

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South West Peninsula Management Board

Terms of Reference

1. Introduction and Authority

1.1. The South West Peninsula Management Board (SWPMB) is established by the South West Peninsula Board as a Committee of the Board in accordance with the Constitutions, Standing Orders and Scheme of Reservation and Delegation of both NHS Cornwall and Isles of Scilly (CIOS) and NHS Devon Integrated Care Boards (ICBs).

1.2. These Terms of Reference (ToR) set out the membership, remit, responsibilities and reporting arrangements of the SWPMB and may only be changed with the approval of the South West Peninsula Board.

1.3. The SWPMB is authorised by the South West Peninsula Board to investigate and report on any activity within its ToR.

2. Purpose and Responsibilities

Purpose

2.1 The purpose of the SWPMB is to support and advise the Chief Executive Officer (CEO) of NHS CIOS and NHS Devon ICB Cluster in the discharge of their executive and statutory functions.

Responsibilities

2.2 The SWPMB's responsibilities will be driven by the objectives set out by the South West Peninsula Board the associated risks to their delivery.

2.3 An annual programme of business will be agreed at the start of the financial year in order to facilitate the delivery of the objectives set by the South West Peninsula Board; however, this programme of business will be flexible to new and emerging priorities and risks.

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2.4 The SWPMB will ensure executive oversight of business (including ensuring an appropriate forward plan) progressing to the South West Peninsula Board and its Assurance Committees.

2.5 The SWPMB's responsibilities can be categorised as follows:

Objectives and strategy

2.6 Formulate and recommend strategies (ensuring that they have appropriate detail with regard to delivery to enable ongoing Board assurance in respect of this.) for the South West Peninsula Board in the development of its business, having regard to the interests of the populations of both CIOS and Devon.

Performance and operations

2.7 Recommend high level budgets and financial plans to be agreed by the South West Peninsula Board and, following their adoption, ensure the achievement of these budgets and plans that are monitored and assured at Board Assurance Committees.

2.8 Monitor performance and take action to ensure targets, objectives and key performance indicators are delivered as agreed by the South West Peninsula Board.

2.9 Agree and keep under review the budgets for the different teams within NHS CIOS and NHS Devon Cluster to ensure that they fall within agreed targets.

2.10 Optimise the allocation and adequacy of NHS CIOS and NHS Devon resources.

2.11 Deliver commissioning intentions to ensure the NHS 10 Year Plan

System leadership and oversight

2.12 Ensure delivery of the proposed merger of NHS Cornwall and Isles of Scilly and NHS Devon

2.13 Provide effective leadership within the CIOS and One Devon Integrated Care Systems to ensure delivery of the South West Peninsula Board's strategic objectives.

2.14 Provide assurance to the South West Peninsula Board around the arrangements for discharging, and implications of, NHS CIOS and NHS Devon responsibilities in respect of the NHS Oversight Framework.

Human resources

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2.15 Ensure appropriate levels of authority are delegated to senior management throughout NHS CIOS and NHS Devon.

2.16 Ensure the provision of adequate management development and succession planning.

Organisational structure and risk management

2.17 Ensure the organisational structure of the NHS CIOS and NHS Devon Cluster is fit for purpose, with highly performing teams which operate together effectively.

2.18 Ensure the control, co-ordination and monitoring within the NHS CIOS and NHS Devon Cluster of risk and internal controls.

2.19 Ensure compliance with relevant legislation and regulations.

2.20 Safeguard the integrity of management information and financial reporting systems.

3. Membership

3.1 Members of the SWPMB shall be appointed by the NHS CIOS and NHS Devon Cluster CEO.

Chair & Vice Chair

3.2 The SWPMB will be chaired by the NHS CIOS and NHS Devon Cluster CEO.

3.3 There will be no Vice Chair of the SWPMB (unless a deputy cluster CEO is appointed), instead, if the NHS CIOS and NHS Devon Cluster CEO is unable to chair a meeting, they will ask the most appropriate NHS CIOS and NHS Devon Cluster Chief Officer to do this on their behalf.

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

Membership

3.5 The membership of the SWPMB shall be constituted as follows:

- Chief Executive Officer (Chair)
- Chief Clinical Officer (Chief Nursing Officer)
- Chief Population Health Officer
- Chief Financial Officer
- Chief Place & Transformation Officer (Chief Medical Officer)
- Chief Strategic Planning & Commissioning Officer
- Chief People Officer
- Company Secretary
- Interim Transformation Director (Devon)

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Other Attendees

3.6 Only members of the SWPMB have the right to attend and vote at SWPMB meetings, however all meetings of the SWPMB will also be attended by the following individuals who are not members of the SWPMB and therefore do not have voting rights.

- NHS CIOS and NHS Devon Corporate Office/Corporate Governance Team representative to take minutes

3.7 Other attendees may be invited to attend all or part of any meeting as and when the SWPMB considers they have expertise that would be relevant to the responsibilities of the SWPMB.

3.8 The Chair of the SWPMB 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.

Attendance

3.9 Members of the SWPMB may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are normally expected to attend at least 75% of meetings during the year.

3.10 When a member of the SWPMB is unable to attend, a nominated formal deputy with sufficient authority must attend in their place. Deputies will have the decision making and voting rights of the person they are representing.

4. Quorum, Decisions and Voting

Quorum

4.1 For meetings to be quorate, a minimum of 50% of members (i.e., 4 members) is required.

4.2 For clarity:

a) No person can act in more than one capacity when determining the quorum.

b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

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4.3 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

4.4 In line with the Standing Orders of NHS CIOS and NHS Devon, it is expected that decisions will be reached by consensus. Should this not be possible, each member of the SWPMB will have one vote, the process for which is set out below:

a) All members of the SWPMB (or nominated deputies) who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the SWPMB are set out at paragraph 3.5; attendees and observers do not have voting rights.)

b) Absent members may not vote by proxy. Absence is defined as not being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so.

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

d) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the Chief Officer identified as meeting chair or, if appointed, the Vice Chair) will have a second and casting vote.

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

4.5 The SWPMB will usually meet on a monthly basis. For urgent decisions, the Chair may call a meeting at a notice of 2 days, setting out the reason for the urgency and the decision to be taken.

4.6 When there is an urgent matter where a decision is required outside of the meeting (which cannot wait for the next scheduled meeting), the Chair of the SWPMB may make a decision after conferring with at least two other members ("Chair's Action").

4.7 When Chair's Action has been taken then the next quorate meeting of the SWPMB must ratify it. Urgent decisions will only be taken when there is insufficient time available for the decision to be delayed until the next meeting.

5. Ways of Working

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5.1 All Members are expected to attend face to face for the meeting, in the location indicated by the Chair of the SWPMB.

5.2 All members of the SWPMB will have due regard to and operate within the Constitution of both NHS CIOS and NHS Devon, their Standing Orders, Standing Financial Instructions and other financial procedures.

5.3 Members of the SWPMB will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

5.4 Members of the SWPMB must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

5.5 All members of the SWPMB are expected to comply with all relevant policies and procedures relating to confidentiality and information governance, noting the sensitivity of the information that will be considered by the SWPMB.

5.6 A Register of Interests will be reviewed at each SWPMB meeting. Those in attendance will be asked by the Chair of the SWPMB to declare any interests at the beginning of each meeting. If a member feels compromised by any agenda item, they should declare a conflict of interest and agreement reached as the action to be taken as set out in the NHS CIOS and NHS Devon Conflicts of Interest Policies.

6. Reporting Arrangements

6.1 The Chair of the SWPMB shall report formally to the South West Peninsula Board on its proceedings after each meeting on all matters within its duties and responsibilities. The report shall be presented to the public meeting of the South West Peninsula Board. The report will provide assurance to the South West Peninsula Board on the work of the SWPMB and shall draw to the attention of the South West Peninsula Board any issues that require disclosure to the South West Peninsula Board or require further action. Matters for significant risk will be escalated through the Board Assurance Framework.

6.2 The SWPMB shall undertake an annual self-assessment of its own performance against its annual programme of business, membership and ToR. The outcome of this self-assessment will be included within the Review of Corporate Governance reported to the South West Peninsula Board on an annual basis.

7. Meetings and Administration

Frequency of Meetings

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7.1 The SWPMB will meet each month. Additional meetings may take place as required.

7.2 Arrangements and notice for calling meetings are set out in the NHS CIOS and NHS Devon Standing Orders.

Administration

7.3 The SWPMB shall be supported by an administrator from within the NHS CIOS and NHS Devon Corporate Office/Corporate Governance Team. Their duties in this respect will include:

a) Agreement of agendas with the Chair and attendees.
b) Preparation, collation and circulation of papers in good time.
c) Ensuring that those invited to each meeting attend, highlighting any concerns to Chair (including interests of members that may conflict with an agenda item).
d) Taking the minutes and helping the Chair to prepare reports to the South West Peninsula Board.
e) Keeping a record of matters arising and issues to be carried forward.
f) Maintaining records of members' appointments and renewal dates.
g) Ensuring that action points are taken forward between meetings.
h) Ensuring that members receive the development and training they need.
i) Providing appropriate support to the Chair and members.

7.4 Following each meeting of the SWPMB, the administrator will:

a) Maintain an attendance log and follow up as appropriate after each meeting to ensure the SWPMB adheres to the required frequency of attendance by members.
b) Maintain a decisions log of reporting arrangements into each formal meeting of the SWPMB.
c) Maintain a log of summary written reports provided to the South West Peninsula Board from formal meetings of the SWPMB.

8. Review of Terms of Reference

8.1 These ToR will be reviewed at least annually and earlier if required. Any proposed amendments to the ToR will be submitted to the South West Peninsula Board for approval.

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Document Control

Document Reference	South West Peninsula Management Board ToR
Version	V.1
Senior Responsible Officer	Philippa Harding, Company Secretary, NHS Cornwall and Isles of Scilly and NHS Devon
Approval by	South West Peninsula Board
Date last reviewed/ approved	28 May 2026
Next review date	Before 31 May 2027

Change Record

Date	Change	Comments

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Transition Steering Group

Terms of Reference

1. Purpose and authority

1.1 The Transition Steering Group (the TSG) is established to oversee the establishment and implementation of Cluster arrangements between NHS Devon and NHS Cornwall and the Isles of Scilly (CIOS) Integrated Care Boards (the ICBs) in the first instance. Once the organisational changes required to support the Cluster arrangement have been completed, the TSG will oversee the work required to ensure readiness for the formal merger of the ICBs on 01 April 2027.

2. Objectives

2.1 The TSG's primary objectives are to:

- **Oversee the clustering transition process** between NHS CIOS and NHS Devon Integrated Care Boards in line with NHS England requirements
- **Ensure safe and effective transition** of functions, governance arrangements, and operational activities
- **Manage risks and interdependencies** arising from the clustering arrangements
- **Facilitate stakeholder engagement** and communication throughout the transition period
- **Monitor progress** against agreed timelines and deliverables
- **Ensure compliance** with regulatory requirements and NHS England guidance
- **Support staff** through the transition process, including change management and workforce planning

3. Scope and Responsibilities

3.1 Strategic Oversight

- Develop and approve the overall transition strategy and implementation plan
- Monitor progress against key milestones and deliverables

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- Escalate significant risks or issues to the South West Peninsula Board (the joint committee established by NHS CIOS and NHS Devon Integrated Care Boards to enable the Cluster)
- Ensure alignment with NHS England's Model ICB Blueprint and clustering guidance

3.2 Governance and Legal

- Oversee the development of new governance structures for the Cluster
- Ensure legal and regulatory compliance throughout the transition
- Coordinate with NHS England on approval processes and reporting requirements

3.3 Operational Integration

- Oversee the integration of operational functions and systems
- Monitor the establishment of shared leadership arrangements
- Ensure continuity of services during the transition period
- Approve arrangements for shared back-office functions and support services

3.4 Financial Management

- Oversee the financial aspects of the clustering arrangement
- Monitor achievement of required cost reductions
- Ensure financial controls and reporting mechanisms are maintained
- Approve budget allocations for transition activities

3.5 People and Culture

- Oversee workforce planning and staff consultation processes
- Monitor staff engagement and wellbeing during transition
- Ensure appropriate support for affected staff members
- Approve communications and engagement strategies

3.6 Quality and Safety

- Ensure patient safety and quality of care are maintained throughout the transition
- Monitor impact on service delivery and patient outcomes
- Oversee risk management processes during the transition period

4. Membership

4.1 Core membership

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- **Cluster Chair**
- **Cluster Chief Executive**
- **Non-Executive Member** Chair of the People, Customer Experience and Equity Committee
- **Chief Finance Officer**

- **Chief People Officer**

4.2 Regular attendees

- Company Secretary
- When clinical or quality issues are on the agenda, the Chief Clinical Officer and Chief Place and Transformation Officer

4.3 Additional attendees

- The TSG may invite other individuals to attend meetings as required.

Meetings and quorum

5.1 Frequency

- The TSG shall meet **weekly** during the active transition period
- Additional meetings may be convened at the discretion of the Chair or upon request from any three TSG members

5.2 Quorum

The quorum for meetings shall be:

- At least one of either the Cluster Chair or Cluster Chief Executive
- At least one non-executive member (who may be the Cluster Chair)
- At least two Chief Officers

5.3 Decision Making

- Decisions will normally be reached by consensus
- Where consensus cannot be achieved, decisions will be referred to the South West Peninsula Board
- Emergency decisions may be taken by the Cluster Chair in consultation with Cluster Chief Executive, subject to ratification at the next meeting

Reporting and Accountability

6.1 Board Reporting

- The TSG shall report to each meeting the South West Peninsula Board whilst it exists

- Written reports shall be provided highlighting:
  - Progress against key milestones
  - Significant risks or issues
  - Decisions taken and recommendations made
  - Financial and operational updates

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6.2 External Reporting

- The TSG shall ensure compliance with NHS England reporting requirements
- Regular updates shall be provided to NHS England Regional Team
- Stakeholder communications shall be coordinated through agreed channels

6.3 Public Accountability

- TSG meetings shall be conducted in private due to the commercially sensitive nature of discussions
- Regular public updates shall be provided through ICB websites and public board and South West Peninsula Board meetings

7. Authority

7.1 Financial Delegation

The TSG is authorised to:

- Approve interim operational arrangements during transition
- Authorise temporary staffing arrangements
- Approve communication and engagement plans
- Establish working groups and task forces as required

7.3 Limitations

The TSG **cannot**:

- Make decisions that fundamentally alter the statutory responsibilities of either ICB
- Approve permanent changes to ICB Constitutions (these require Board approval)
- Commit to expenditure exceeding the approved transition budget without South West Peninsula Board and/or individual Board approval
- Make decisions that would compromise patient safety or regulatory compliance

8. Working Groups and Support

8.1 Working Groups

The TSG may establish time-limited working groups to address specific aspects of the transition.

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8.2 Programme Management

- A dedicated programme management office shall support the TSG
- Regular programme reporting shall be provided to the TSG
- Risk and issue registers shall be maintained and reviewed at each meeting

9. Review and Dissolution

9.1 Review

These terms of reference shall be reviewed every six months and amended as necessary.

9.2 Dissolution

The TSG shall be dissolved upon:

- Successful completion of the clustering transition
- Formal merger of the ICBs
- Decision by both ICB Boards to discontinue the clustering arrangement
- Direction from NHS England to cease clustering activities

10. Effective Date

These terms of reference shall take effect from 21 August 2025 and remain in force until amended or revoked by the TSG.

Next Review Date: by 31 May 2027

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Document Control

Document Reference	TSG ToR
Version	V.2.1
Senior Responsible Officer	Philippa Harding, Company Secretary, NHS Cornwall and Isles of Scilly and NHS Devon Cluster
Approval by	South West Peninsula Board
Date last reviewed/ approved	28 May 2026
Next review date	Before 31 May 2027

Change Record

Date	Change	Comments
26/02/26	Membership	Membership amended to reflect approval of and appointment to executive roles in Phase One of organisational change associated with cluster arrangement.

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NHS Devon

NHS Cornwall and Isles of Scilly

South West Peninsula Planning Committee

Terms of Reference

1. Introduction and purpose

1.1. The South West Peninsula Planning Committee (the Committee) has been established by South West Peninsula Board to enable NHS Cornwall and the Isles of Scilly Integrated Care Board and NHS Devon Integrated Care Board (the Partner ICBs) to fulfill their obligations with regard to the development of credible, integrated five-year plans, demonstrating how the sustainable provision of care (from both a financial and quality perspective) will be secured over the medium term.

1.2. The Committee will enable the Partner ICBs to agree the "next year" at a monthly level and the following two years at a quarterly level, having gained in principle high level agreement on plans (financial and quality) with NHS system providers by the end of December each year, ready to start from 1 April each year

1.3. This means providing assurance to the South West Peninsula Board that the plans being developed by the Partner ICBs will:

- build and align across time horizons, joining up strategic and operational planning
- are co-ordinated and coherent across organisations and different spatial levels
- demonstrate robust triangulation between finance, quality, activity and workforce

2. Responsibilities

2.1 The Committee shall be responsible for overseeing and coordinating the strategic and operational planning processes of the Partner ICBs for the "next year" and the medium term (including Medium Term Financial Plans (MTFPs)). This planning responsibility includes seeking assurance with regard to the implementation of inclusive, collaborative and fit for purpose planning processes and approaches as well as effective and robust planning

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outcomes that will lead to agreement of commissioning intentions and budgets.

3. Membership

3.1 Members of the Committee shall be appointed by the South West Peninsula Board and cannot be varied without the agreement of that Board.

Chair & Deputy Chair

3.2 The Committee will be chaired by the Cluster Chair

3.3 The Committee Chair will appoint a Deputy Chair from amongst the membership of the Committee. This must be a Non-Executive Member, who has the requisite skills and experience to act in that capacity.

3.4 The Committee Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference, in line with the Standing Orders of both Partner ICBs.

Membership

3.5 The membership of the Committee shall be constituted as follows:

- Chair, NHS Cornwall and Isles of Scilly and NHS Devon Cluster (Committee Chair)
- Deputy Chair, NHS Cornwall and Isles of Scilly
- Deputy Chair, NHS Devon
- 4 x Non-Executive Members
- Chief Executive Officer
- Chief Finance Officer
- Chief Strategic Commissioning and Planning Officer
- Chief Clinical Officer (Chief Nursing Officer)
- Chief People Officer
- Chief Population Health Officer
- Chief Place and Transformation Officer (Chief Medical Officer)

Other participants

3.6 Only members of the Committee have the right to attend and vote at Committee meetings; however, meetings of the Committee will also include the following participants who are not members:

- Company Secretary

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3.7 Other attendees may be invited to attend all or part of any meeting as and when the Chair of the Committee considers they have expertise that would be relevant to the responsibilities of the Committee.

3.8 The Chair of the Committee 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.

Attendance

3.9 Members of the Committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair of the Committee. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members and regular attendees are expected to attend at least 75% of meetings during the year, except where agreed by the Chair of the Committee.

Conflicts of Interest

3.10 Members' conflicts of interests to be held by their respective organisations and made available on organisations' websites.

3.11 All potential conflicts of interest pertinent to agenda items must be declared and recorded at the start of each meeting.

4. Quorum, Decisions and Voting

Quorum

4.1. The quorum for meetings of the Committee will be 5 members, including:

a) Chair or Deputy Chair
b) At least 2 Executive Members
c) At least 2 Non-Executive Members

4.2. If any member of the Committee is unable to participate 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.

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

Decision Making and Voting

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4.4. In line with the Standing Orders of each of the Partner ICBs, it is expected that decisions will be reached by consensus. Should this not be possible, each member of the Committee will have one vote, the process for which is set out below:

a) All members of the Committee who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the Committee are set out at paragraph 3.5; attendees and observers do not have voting rights).

b) Absent members may not vote by proxy. Absence is defined as not being present at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so.

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

d) If an equal number of votes are cast for and against a resolution, then the Chair of the Committee (or in their absence, the Deputy Chair) will have a second and casting vote.

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

f) At least 50% of the attending NEMs must vote to support any measure, where a vote is taken.

4.5. For urgent issues, the Chair of the Committee may call a meeting at a notice of 5 days, setting out the reason for the urgency and the issue to be addressed.

5. Ways of Working

5.1 All members of the Committee will have due regard to and operate within the Constitutions of the Partners, their Standing Orders, Standing Financial Instructions and other financial procedures.

5.2 Members of the Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

5.3 Members of the Committee must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

5.4 A Register of Interests will be reviewed at each Committee meeting. Those in attendance will be asked by the Chair of the Committee to declare any interests at the beginning of each meeting. If a member of the Committee feels compromised by any agenda item, they should declare a conflict of interest and agreement reached as the action to be taken as set out in the Partner ICBs' Conflicts of Interest Policy.

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5.5 If necessary, the Committee may draw on third-party support to assist it in resolving any disputes, such as peer review or support from NHS England.

6. Reporting Arrangements

6.1 The Committee is accountable to the South West Peninsula Board and shall report after each meeting on how it has discharged its responsibilities.

6.2 The Committee shall undertake an annual self-assessment of its own performance against its annual programme of business, membership and Terms of Reference.

7. Meetings and Administration

Frequency of Meetings

7.1 The Committee will meet every month between September and March and then every other month for the rest of the year.

7.2 The Chair of the Committee may ask Committee to convene further meetings to discuss particular issues they consider pertinent.

7.3 Arrangements and notice for calling meetings are set out in the Partner ICBs' Standing Orders.

7.4 Whilst in person attendance is expected at most meetings, when an urgent meeting is called members of the Committee may participate by telephone, video or by other electronic means where they are available and with the prior agreement of the Cluster Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.

Publication of notices, minutes and papers

7.5 The Chair of the Committee shall see that an agenda listing the business to be conducted and supporting documentation, is published one week (or, in the case of a special meeting, two days) prior to the date of the meeting.

7.6 The proceedings and decisions taken by the Committee shall be recorded in minutes, and those minutes circulated in draft form within two weeks of the date of the meeting. The Committee shall confirm those minutes at its next meeting.

Administration

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7.7 The Committee shall be supported by an administrator from within the Partner ICBs' Corporate Governance team. Their duties in this respect will include:

a) Agreement of agendas with the Chair and attendees.
b) Preparation, collation and circulation of papers in good time.

c) Ensuring that those invited to each meeting attend, highlighting any concerns to Chair (including interests of members that may conflict with an agenda item).
d) Taking the minutes and helping the Chair to prepare any necessary reports to the Partners' Boards.
e) Keeping a record of matters arising and issues to be carried forward.
f) Maintaining records of members' appointments and renewal dates.
g) Ensuring that action points are taken forward between meetings.
h) Ensuring that members receive the development and training they need.
i) Providing appropriate support to the Chair and members.

7.8 Following each meeting of the Committee, the administrator will also:

a) Maintain an attendance log and follow up as appropriate after each meeting to ensure the Committee adheres to the required frequency of attendance by members; and
b) Maintain a decisions log of reporting arrangements into each formal meeting of the Committee.

8. Review of Terms of Reference

8.1 The Terms of Reference will be reviewed annually or earlier if required. Any proposed amendments will be submitted to the SWP Board for approval.

Document Control

Document Reference	SWPPC ToR
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Senior Responsible Officer	Philippa Harding, Company Secretary
Author/s	Head of Corporate Governance
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Date	Version	Comments
19.03.26	V0.1	Annual Committee Review. Document Control template amended. Membership Updated

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NHS
Cornwall and Isles of Scilly

Cornwall and Isles of Scilly Finance, Performance and Quality Committee

Terms of Reference

1. Introduction and purpose

1.1. The South West Peninsula Board has established the Cornwall & Isles of Scilly Finance, Performance and Quality Committee (the Committee) to enable the NHS Cornwall & the Isles of Scilly Integrated Care Board to oversee and seek assurance that:

1.1.1. NHS Cornwall & the Isles of Scilly is maximising value for money from the use of its public funding and delivering its performance targets set out in the Operational Plan for the year.

1.1.2. Patients are receiving safe, high-quality and timely healthcare with equal access to services and seamless handovers between different parts of the Cornwall and Isles of Scilly system.

2. Responsibilities

2.1 The Committee shall be responsible for:

2.1.1 Seeking assurance around the arrangements for discharging, and implications of, NHS Cornwall & Isles of Scilly Integrated Care Board's responsibilities in relation to ensuring financial management achieves value for money, efficiency and effectiveness in the sustainable use of resources with a continuing focus on cost reduction, cost avoidance and achievement of efficiency targets (both financial and non-financial).

2.1.2 Seeking assurance around the arrangements for discharging, and implications of, NHS Cornwall & Isles of Scilly Integrated Care Board's responsibilities in respect of quality of care, access and outcomes.

2.1.3 Seeking assurance around the arrangements for discharging NHS Cornwall & Isles of Scilly Integrated Care Board's responsibilities in relation to securing continuous improvement in the quality of medical services.

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2.1.4 Monitoring and assessing NHS Cornwall & Isles of Scilly Integrated Care Board's Board Assurance Framework (BAF).

3. Membership

3.1 Members of the Committee shall be appointed by the South West Peninsula Board and cannot be varied without the agreement of that Board.

Chair & Deputy Chair

3.2 The Committee will be chaired by the Deputy Chair of NHS Cornwall & Isles of Scilly Integrated Care Board.

3.3 The Committee Chair will appoint a Deputy Chair from amongst the membership of the Committee. This must be a Non-Executive Member of the NHS Cornwall & Isles of Scilly and NHS Devon Integrated Care Board's (the Partner ICBs) Boards, who has the requisite skills and experience to act in that capacity.

3.4 The Committee Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference, in line with the Standing Orders of the Partner ICB's Boards.

Membership

3.5 The membership of the Committee shall be constituted as follows:

- Deputy Chair, NHS Cornwall & Isles of Scilly Integrated Care Board (Committee Chair)
- Up to 2x Non-Executive Members, NHS Cornwall & Isles of Scilly and NHS Devon Cluster (one of whom will be the Deputy Chair of the Committee)
- Interim Chief Executive Officer (CEO)

Other participants

3.6 Only members of the Committee have the right to attend and vote at Committee meetings; however, meetings of the Committee will also include the following participants who are not members:

- Company Secretary
- Chief Finance Officer,
- Chief Clinical Officer (CNO)
- Chief People Officer

3.7 Other attendees may be invited to attend all or part of any meeting as and when the Chair of the Committee considers they have expertise that would be relevant to the responsibilities of the Committee.

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3.8 The Chair of the Committee 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.

Attendance

3.9 Members of the Committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair of the Committee. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are expected to attend at least 75% of meetings during the year. Members and regular attendees are expected to attend at least 75% of meetings during the year, except where agreed by the Chair of the Committee.

Conflicts of Interest

3.10 Members' conflicts of interests to be held by their respective organisations and made available on the organisations' websites.

3.11 All potential conflicts of interest pertinent to agenda items must be declared and recorded at the start of each meeting.

4. Quorum, Decisions and Voting

Quorum

4.1. The quorum for meetings of the Committee will be 2 members, both of whom should be Non-Executive Members

4.2. If any member of the Committee is unable to participate 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.

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

Decision Making and Voting

4.4. In line with the Standing Orders of each of the Partner ICBs, it is expected that decisions will be reached by consensus. Should this not be possible, each member of the Committee will have one vote, the process for which is set out below:

a) All members of the Committee who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the Committee are set out at paragraph 3.5; attendees and observers do not have voting rights).

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b) Absent members may not vote by proxy. Absence is defined as not being present at the time of the vote, but this does not preclude anyone

attending via teleconference or other virtual means from exercising their right to vote if eligible.

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

d) If an equal number of votes are cast for and against a resolution, then the Chair of the Committee (or in their absence, the Deputy Chair) will have a second and casting vote.

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

f) At least 50% of the attending NEMs must vote to support any measure, where a vote is taken.

4.5. For urgent issues, the Chair of the Committee may call a meeting at 5 days' notice, setting out the reason for the urgency and the issue to be addressed.

5. Ways of Working

5.1 All members of the Committee will have due regard for and operate within the Constitutions of the Partner ICBs, their Standing Orders, Standing Financial Instructions and other financial procedures.

5.2 Members of the Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

5.3 Members of the Committee must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

5.4 A Register of Interests will be reviewed at each Committee meeting. Those in attendance will be asked by the Chair of the Committee to declare any interests at the beginning of each meeting. If a member of the Committee feels compromised by any agenda item, they should declare a conflict of interest and agree on the action to be taken as set out in the Partner ICBs' Conflicts of Interest Policy.

5.5 If necessary, the Committee may draw on third-party support to assist it in resolving any disputes, such as peer review or support from NHS England.

6. Reporting Arrangements

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6.1 The Committee is accountable to the South West Peninsula Board and shall report after each meeting on how it has discharged its responsibilities.

6.2 The Committee shall undertake an annual self-assessment of its own performance against its annual programme of business, membership and Terms of Reference.

7. Meetings and Administration

Frequency of Meetings

7.1 The Committee will meet monthly.

7.2 The Chair of the Committee may ask the Committee to convene further meetings to discuss particular issues they consider pertinent.

7.3 Arrangements and notice for calling meetings are set out in the Partner ICBs' Standing Orders.

7.4 Whilst in person attendance is expected at most meetings, when an urgent meeting is called members of the Committee may participate by telephone, video or by other electronic means where they are available and with the prior agreement of the Cluster Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.

Publication of notices, minutes and papers

7.5 The Chair of the Committee shall see that an agenda listing the business to be conducted and supporting documentation is published one week (or, in the case of a special meeting, two days) before the date of the meeting.

7.6 The proceedings and decisions taken by the Committee shall be recorded in minutes, and those minutes circulated in draft form within two weeks of the date of the meeting. The Committee shall confirm those minutes at its next meeting.

Administration

7.7 The Committee shall be supported by an administrator from within the Partner ICBs' Corporate Governance teams. Their duties in this respect will include:

a) Agreement of agendas with the Chair and attendees.
b) Preparation, collation and circulation of papers in good time.
c) Ensuring that those invited to each meeting attend, highlighting any concerns to the Chair (including interests of members that may conflict with an agenda item).
d) Taking the minutes and helping the Chair to prepare any necessary reports to the Partners' Boards.
e) Keeping a record of matters arising and issues to be carried forward.
f) Maintaining records of members' appointments and renewal dates.
g) Ensuring that action points are taken forward between meetings.
h) Ensuring that members receive the development and training they need.

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i) Providing appropriate support to the Chair and members.

7.8 Following each meeting of the Committee, the administrator will also:

a) Maintain an attendance log and follow up as appropriate after each meeting to ensure the Committee adheres to the required frequency of attendance by members; and
b) Maintain a decision log of reporting arrangements in each formal meeting of the Committee.

8. Review of Terms of Reference

8.1 The Terms of Reference will be reviewed annually or earlier if required. Any proposed amendments will be submitted to the Partner ICBs' Boards for approval.

Document Control

Document Reference	CFPQC ToR
Version	V1.1
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Author/s	Head of Corporate Governance
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19.03.26	R Plowman and K Kingan	Draft	V0.1	Annual Committee Review. Document Control template amended. Roles Updated following organisational change

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Devon Finance, Performance and Quality Committee

Terms of Reference

1. Introduction and purpose

1.1. The Devon Finance, Performance and Quality Committee (the Committee) has been established by the South West Peninsula Board to enable the NHS Devon Integrated Care Board to oversee and seek assurance that:

1.1.1. NHS Devon is maximising value for money from the use of its public funding and delivering its performance targets set out in the Operational Plan for the year.
1.1.2. Patients are receiving safe, high-quality and timely healthcare with equal access to services and seamless handovers between different parts of the Devon system.

2. Responsibilities

2.1 The Committee shall be responsible for:

2.1.1 Seeking assurance around the arrangements for discharging, and implications of, NHS Devon Integrated Care Board's responsibilities in relation to ensuring financial management achieves value for money, efficiency and effectiveness in the sustainable use of resources with a continuing focus on cost reduction, cost avoidance and achievement of efficiency targets (both financial and non-financial).
2.1.2 Seeking assurance around the arrangements for discharging, and implications of, NHS Devon Integrated Care Board's responsibilities in respect of quality of care, access and outcomes.
2.1.3 Seeking assurance around the arrangements for discharging NHS Devon Integrated Care Board's responsibilities in relation to securing continuous improvement in the quality of medical services.
2.1.4 Monitoring and assessing NHS Devon Integrated Care Board's Board Assurance Framework (BAF)

3. Membership

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3.1 Members of the Committee shall be appointed by the South West Peninsula Board and cannot be varied without the agreement of that Board.

Chair & Deputy Chair

3.2 The Committee will be chaired by the Deputy Chair of NHS Devon Integrated Care Board.

3.3 The Committee Chair will appoint a Deputy Chair from amongst the membership of the Committee. This must be a Non-Executive Member of the NHS Cornwall and Isles of Scilly and NHS Devon Integrated Care Boards (the Partner ICBs), who has the requisite skills and experience to act in that capacity.

3.4 The Committee Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference, in line with the Standing Orders of the Partner ICBs Boards.

Membership

3.5 The membership of the Committee shall be constituted as follows:

- Deputy Chair, NHS Devon Integrated Care Board (Committee Chair)
- Up to 2x Non-Executive Members (one of whom will be the Deputy Chair of the Committee)
- Interim Chief Executive Officer (CEO)

Other participants

3.6 Only members of the Committee have the right to attend and vote at Committee meetings; however, meetings of the Committee will also include the following participants who are not members:

- Audit and Risk Committee Chair
- Company Secretary
- Chief Finance Officer,
- Chief Clinical Officer (CNO),
- Chief Place and Transformation Officer (Chief Medical Officer)
- Chief Strategic Commissioning and Planning Officer,
- Chief People Officer

3.7 Other attendees may be invited to attend all or part of any meeting as and when the Chair of the Committee considers they have expertise that would be relevant to the responsibilities of the Committee.

3.8 The Chair of the Committee 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.

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Attendance

3.9 Members of the Committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair of the Committee. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members and regular attendees are expected to attend at least 75% of meetings during the year, except where agreed by the Chair of the Committee.

Conflicts of Interest

3.10 Members' conflicts of interests to be held by their respective organisations and made available on the organisations' websites.

3.11 All potential conflicts of interest pertinent to agenda items must be declared and recorded at the start of each meeting.

4. Quorum, Decisions and Voting

Quorum

4.1. The quorum for meetings of the Committee will be 2 members, both of whom should be Non-Executive Members

4.2. If any member of the Committee is unable to participate 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.

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

Decision Making and Voting

4.4. In line with the Standing Orders of each of the Partner ICBs, it is expected that decisions will be reached by consensus. Should this not be possible, each member of the Committee will have one vote, the process for which is set out below:

a) All members of the Committee who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the Committee are set out at paragraph 3.5; attendees and observers do not have voting rights).

b) Absent members may not vote by proxy. Absence is defined as not being present at the time of the vote, but this does not preclude anyone attending via teleconference or other virtual means from exercising their right to vote if eligible.

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c) A resolution will be passed if more votes are cast for the resolution than

against it.

d) If an equal number of votes are cast for and against a resolution, then the Chair of the Committee (or in their absence, the Deputy Chair) will have a second and casting vote.

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

f) At least 50% of the attending NEMs must vote to support any measure, where a vote is taken.

4.5. For urgent issues, the Chair of the Committee may call a meeting with 5 days' notice, setting out the reason for the urgency and the issue to be addressed.

5. Ways of Working

5.1 All members of the Committee will have due regard for and operate within the Constitutions of the Partner ICBs, their Standing Orders, Standing Financial Instructions and other financial procedures.

5.2 Members of the Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

5.3 Members of the Committee must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

5.4 A Register of Interests will be reviewed at each Committee meeting. Those in attendance will be asked by the Chair of the Committee to declare any interests at the beginning of each meeting. If a member of the Committee feels compromised by any agenda item, they should declare a conflict of interest and agree on the action to be taken as set out in the Partner ICBs' Conflicts of Interest Policy.

5.5 If necessary, the Committee may draw on third-party support to assist it in resolving any disputes, such as peer review or support from NHS England.

6. Reporting Arrangements

6.1 The Committee is accountable to the South West Peninsula Board and shall report after each meeting on how it has discharged its responsibilities.

6.2 The Committee shall undertake an annual self-assessment of its own performance against its annual programme of business, membership and Terms of Reference.

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7. Meetings and Administration

Frequency of Meetings

7.1 The Committee will meet monthly.

7.2 The Chair of the Committee may ask the Committee to convene further meetings to discuss particular issues they consider pertinent.

7.3 Arrangements and notice for calling meetings are set out in the Partner ICBs' Standing Orders.

7.4 Whilst in person attendance is expected at most meetings, when an urgent meeting is called members of the Committee may participate by telephone, video or by other electronic means where they are available and with the prior agreement of the Cluster Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.

Publication of notices, minutes and papers

7.5 The Chair of the Committee shall see that an agenda listing the business to be conducted and supporting documentation, is published one week (or, in the case of a special meeting, two days) before the date of the meeting.

7.6 The proceedings and decisions taken by the Committee shall be recorded in minutes, and those minutes circulated in draft form within two weeks of the date of the meeting. The Committee shall confirm those minutes at its next meeting.

Administration

7.7 The Committee shall be supported by an administrator from within the Partner ICBs' Corporate Governance teams. Their duties in this respect will include:

a) Agreement of agendas with the Chair and attendees.
b) Preparation, collation and circulation of papers in good time.
c) Ensuring that those invited to each meeting attend, highlighting any concerns to the Chair (including interests of members that may conflict with an agenda item).
d) Taking the minutes and helping the Chair to prepare any necessary reports to the Partners' Boards.
e) Keeping a record of matters arising and issues to be carried forward.
f) Maintaining records of members' appointments and renewal dates.
g) Ensuring that action points are taken forward between meetings.
h) Ensuring that members receive the development and training they need.
i) Providing appropriate support to the Chair and members.

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7.8 Following each meeting of the Committee, the administrator will also:

a) Maintain an attendance log and follow up as appropriate after each meeting to ensure the Committee adheres to the required frequency of attendance by members; and
b) Maintain a decision log of reporting arrangements in each formal meeting of the Committee.

8. Review of Terms of Reference

8.1 The Terms of Reference will be reviewed annually or earlier if required. Any proposed amendments will be submitted to the SWP Board for approval.

Document Control

Document Reference	DFPQC ToR
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Author/s	Head of Corporate Governance
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Next review date	By 31 March 2027

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NHS Devon

NHS Cornwall and Isles of Scilly

South West Peninsula Neighbourhood Health Improvement Committee

Terms of Reference

1. Introduction and purpose

1.1. The South West Peninsula Neighbourhood Health Improvement Committee (the Committee) has been established by South West Peninsula Board to enable NHS Cornwall and the Isles of Scilly Integrated Care Board and NHS Devon Integrated Care Board (the Partner ICBs) to seek assurance with regard to the movement of NHS services from hospitals to community-based settings (including wider community services as well as Integrated Neighbourhood Teams) and the objectives of improved patient outcomes and the long-term sustainability of the NHS by providing more care closer to people's homes.

2. Responsibilities

2.1 The Committee shall be responsible for:

2.1.1 Seeking assurance with regard to the progress being made across the Cluster with regard to the shift to community based care, through the move of activities and services from hospitals to settings closer to patients, primarily within primary and community services.

2.1.2 Seeking assurance with regard to the improvement of health outcomes and the reduction of health inequalities.

2.1.3 Overseeing the implementation of strategies to promote healthier lives and reduce the burden of illness, shifting from a reactive model to one focused on proactive health and well-being.

2.1.4 Seeking assurance with regard to the use of digital technologies to give patients more control and choice, improve access to care, and create a comprehensive digital patient record shared across the system.

2.1.5 Seeking assurance of the delivery of patient centred care

2.1.6 Seeking assurance that resources and services are being targeted to improve healthcare outcomes for all communities, with a particular focus on those experiencing health inequalities.

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3. Membership

3.1 Members of the Committee shall be appointed by the South West Peninsula Board and cannot be varied without the agreement of that Board.

Chair & Deputy Chair

3.2 The Committee will be chaired by a Non-Executive Member.

3.3 The Committee Chair will appoint a Deputy Chair from amongst the membership of the Committee. This must be a Non-Executive Member, who has the requisite skills and experience to act in that capacity.

3.4 The Committee Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference, in line with the Standing Orders of both Partner ICBs.

Membership

3.5 The membership of the Committee shall be constituted as follows:

- 3x Non-Executive Members, (one of whom will be the Committee Chair and another will be the Deputy Chair of the Committee)
- Chief Place and Transformation Officer (Chief Medical Officer)
- Chief Clinical Officer (Chief Nursing Officer)
- Chief Strategic Commissioning and Planning Officer

Other participants

3.6 Only members of the Committee have the right to attend and vote at Committee meetings; however, meetings of the Committee will also include the following participants who are not members:

- Company Secretary,

3.7 Other attendees may be invited to attend all or part of any meeting as and when the Chair of the Committee considers they have expertise that would be relevant to the responsibilities of the Committee.

3.8 The Chair of the Committee 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.

Attendance

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3.9 Members of the Committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair of the Committee. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members

and regular attendees are normally expected to attend at least 75% of meetings during the year, except where agreed by the Chair of the Committee.

Conflicts of Interest

3.10 Members' conflicts of interests to be held by their respective organisations and made available on organisations' websites.

3.11 All potential conflicts of interest pertinent to agenda items must be declared and recorded at the start of each meeting.

4. Quorum, Decisions and Voting

Quorum

4.1. The quorum for meetings of the Committee will be 4 members, including:

a) At least 2 Non-Executive Members (including the Chair or Deputy Chair)
b) At least 2 Executive Members

4.2. If any member of the Committee is unable to participate 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.

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

Decision Making and Voting

4.4. In line with the Standing Orders of each of the Partner ICBs, it is expected that decisions will be reached by consensus. Should this not be possible, each member of the Committee will have one vote, the process for which is set out below:

a) All members of the Committee who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the Committee are set out at paragraph 3.5; attendees and observers do not have voting rights).

b) Absent members may not vote by proxy. Absence is defined as not being present at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so.

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

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d) If an equal number of votes are cast for and against a resolution, then the Chair of the Committee (or in their absence, the Deputy Chair) will have a second and casting vote.

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

f) At least 50% of the attending NEMs must vote to support any measure, where a vote is taken.

4.5. For urgent issues, the Chair of the Committee may call a meeting at a notice of 5 days, setting out the reason for the urgency and the issue to be addressed.

5. Ways of Working

5.1 All members of the Committee will have due regard to and operate within the Constitutions of the Partners, their Standing Orders, Standing Financial Instructions and other financial procedures.

5.2 Members of the Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

5.3 Members of the Committee must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

5.4 A Register of Interests will be reviewed at each Committee meeting. Those in attendance will be asked by the Chair of the Committee to declare any interests at the beginning of each meeting. If a member of the Committee feels compromised by any agenda item, they should declare a conflict of interest and agreement reached as the action to be taken as set out in the Partner ICBs' Conflicts of Interest Policy.

5.5 If necessary, the Committee may draw on third-party support to assist it in resolving any disputes, such as peer review or support from NHS England.

6. Reporting Arrangements

6.1 The Committee is accountable to the South West Peninsula Board and shall report after each meeting on how it has discharged its responsibilities.

6.2 The Committee shall undertake an annual self-assessment of its own performance against its annual programme of business, membership and Terms of Reference.

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7. Meetings and Administration

Frequency of Meetings

7.1 The Committee will meet at least six times a year.

7.2 The Chair of the Committee may ask Committee to convene further meetings to discuss particular issues they consider pertinent.

7.3 Arrangements and notice for calling meetings are set out in the Partner ICBs' Standing Orders.

7.4 Whilst in person attendance is expected at most meetings, when an urgent meeting is called members of the Committee may participate by telephone, video or by other electronic means where they are available and with the prior agreement of the Cluster Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.

Publication of notices, minutes and papers

7.5 The Chair of the Committee shall see that an agenda listing the business to be conducted and supporting documentation, is published one week (or, in the case of a special meeting, two days) prior to the date of the meeting.

7.6 The proceedings and decisions taken by the Committee shall be recorded in minutes, and those minutes circulated in draft form within two weeks of the date of the meeting. The Committee shall confirm those minutes at its next meeting.

Administration

7.7 The Committee shall be supported by an administrator from within the Partner ICBs' Corporate Governance teams. Their duties in this respect will include:

a) Agreement of agendas with the Chair and attendees.
b) Preparation, collation and circulation of papers in good time.
c) Ensuring that those invited to each meeting attend, highlighting any concerns to Chair (including interests of members that may conflict with an agenda item).
d) Taking the minutes and helping the Chair to prepare any necessary reports to the Partners' Boards.
e) Keeping a record of matters arising and issues to be carried forward.
f) Maintaining records of members' appointments and renewal dates.
g) Ensuring that action points are taken forward between meetings.
h) Ensuring that members receive the development and training they need.
i) Providing appropriate support to the Chair and members.

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7.8 Following each meeting of the Committee, the administrator will also:

a) Maintain an attendance log and follow up as appropriate after each meeting to ensure the Committee adheres to the required frequency of attendance by members; and
b) Maintain a decisions log of reporting arrangements into each formal meeting of the Committee.

8. Review of Terms of Reference

8.1 These Terms of Reference will be reviewed at least annually and earlier if required. Any proposed amendments will be submitted to the Partner ICBs' Boards for approval.

Document Control

Document Reference	SWPNHIC ToR
Version	V.1
Senior Responsible Officer	Philippa Harding,
Author	Head of Corporate Governance
Approval by	South West Peninsula Board
Date approved	29 May 2026
Date Issued	
Next review date	Before 31 March 2027

Change Record

Date	Version	Summary of Changes
01/04/2026	V0.1	Updated roles to reflect organisational changes Updated Document control and change record tables

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South West Peninsula People, Customer Experience and Equity Committee

Terms of Reference

1. Introduction and purpose

1.1. The South West People, Customer Experience and Equity Committee (the Committee) has been established by South West Peninsula Board to enable NHS Cornwall and the Isles of Scilly Integrated Care Board and NHS Devon Integrated Care Board (the Partner ICBs) to consider and seek assurance in respect of the experiences of people (staff, patients and the public) in relation to the work of the Partner ICBs, ensuring that the Cluster seeks and acts on insights to improve equity within the NHS workforce and the delivery of health outcomes.

2. Responsibilities

2.1 The Committee shall be responsible for:

2.1.1 Providing assurance that public involvement activities are being carried out effectively and meet the statutory duties placed on each ICB.
2.1.2 Ensuring equality and patient experience and feedback is embedded throughout the work of both NHS Cornwall and Isles of Scilly and NHS Devon and the integrated care systems of which they are a part.
2.1.3 Providing assurance on the workforce recruitment, development and retention and wellbeing plans across the Cluster.
2.1.4 Providing assurance around the arrangements for discharging, and implications of, responsibilities in respect of the preventing ill health and reducing inequality.
2.1.5 Providing assurance of the delivery of the population health outcomes, including using benchmarking against other systems
2.1.6 Ensuring plans identify and engage the most marginalised communities in setting, delivering and monitoring health inequality priorities

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3. Membership

3.1 Members of the Committee shall be appointed by the South West Peninsula Board and cannot be varied without the agreement of that Board.

Chair & Deputy Chair

3.2 The Committee will be chaired by a Non-Executive Member of the Partner ICBs' Boards.

3.3 The Committee Chair will appoint a Deputy Chair from amongst the membership of the Committee. This must be a Non-Executive Member of the Partner ICBs' Boards, who has the requisite skills and experience to act in that capacity.

3.4 The Committee Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference, in line with the Standing Orders of both Partner ICBs.

Membership

3.5 The membership of the Committee shall be constituted as follows:

- 3x Non-Executive Members, one of whom will be the Committee Chair, and another will be the Deputy Chair of the Committee)
- Chief Clinical Officer,
- Chief People Officer,
- Chief Population Health Officer

Other participants

3.6 Only members of the Committee have the right to attend and vote at Committee meetings; however, meetings of the Committee will also include the following participants who are not members:

- Company Secretary
- Director of Experience and Engagement

3.7 Other attendees may be invited to attend all or part of any meeting as and when the Chair of the Committee considers they have expertise that would be relevant to the responsibilities of the Committee.

3.8 The Chair of the Committee 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.

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Attendance

3.9 Members of the Committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair of the Committee. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members and regular attendees are normally expected to attend at least 75% of meetings during the year, except where agreed by the Chair of the Committee.

Conflicts of Interest

3.10 Members' conflicts of interests to be held by their respective organisations and made available on organisations' websites.

3.11 All potential conflicts of interest pertinent to agenda items must be declared and recorded at the start of each meeting.

4. Quorum, Decisions and Voting

Quorum

4.1. The quorum for meetings of the Committee will be 5 members, including:

a) Chair or Deputy Chair
b) At least 2 Executive Members
c) At least 2 Non-Executive Members

4.2. If any member of the Committee is unable to participate 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.

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

Decision Making and Voting

4.4. In line with the Standing Orders of each of the Partner ICBs, it is expected that decisions will be reached by consensus. Should this not be possible, each member of the Committee will have one vote, the process for which is set out below:

a) All members of the Committee who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the Committee are set out at paragraph 3.5; attendees and observers do not have voting rights).

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b) Absent members may not vote by proxy. Absence is defined as not being present at the time of the vote, but this does not preclude anyone

attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so.

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

d) If an equal number of votes are cast for and against a resolution, then the Chair of the Committee (or in their absence, the Deputy Chair) will have a second and casting vote.

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

f) At least 50% of the attending NEMs must vote to support any measure, where a vote is taken.

4.5. For urgent issues, the Chair of the Committee may call a meeting at a notice of 5 days, setting out the reason for the urgency and the issue to be addressed.

5. Ways of Working

5.1 All members of the Committee will have due regard to and operate within the Constitutions of the Partners, their Standing Orders, Standing Financial Instructions and other financial procedures.

5.2 Members of the Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

5.3 Members of the Committee must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

5.4 A Register of Interests will be reviewed at each Committee meeting. Those in attendance will be asked by the Chair of the Committee to declare any interests at the beginning of each meeting. If a member of the Committee feels compromised by any agenda item, they should declare a conflict of interest and agreement reached as the action to be taken as set out in the Partner ICBs' Conflicts of Interest Policy.

5.5 If necessary, the Committee may draw on third-party support to assist it in resolving any disputes, such as peer review or support from NHS England.

6. Reporting Arrangements

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6.1 The Committee is accountable to the South West Peninsula Board and shall report after each meeting on how it has discharged its responsibilities.

6.2 The Committee shall undertake an annual self-assessment of its own performance against its annual programme of business, membership and Terms of Reference.

7. Meetings and Administration

Frequency of Meetings

7.1 The Committee will meet every month except in August.

7.2 The Chair of the Committee may ask the Committee to convene further meetings to discuss particular issues they consider pertinent.

7.3 Arrangements and notice for calling meetings are set out in the Partner ICBs' Standing Orders.

7.4 Whilst in person attendance is expected at most meetings, when an urgent meeting is called members of the Committee may participate by telephone, video or by other electronic means where they are available and with the prior agreement of the Cluster Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.

Publication of notices, minutes and papers

7.5 The Chair of the Committee shall see that an agenda listing the business to be conducted and supporting documentation, is published one week (or, in the case of a special meeting, two days) prior to the date of the meeting.

7.6 The proceedings and decisions taken by the Committee shall be recorded in minutes, and those minutes circulated in draft form within two weeks of the date of the meeting. The Committee shall confirm those minutes at its next meeting.

Administration

7.7 The Committee shall be supported by an administrator from within the Partner ICBs' Corporate Governance teams. Their duties in this respect will include:

a) Agreement of agendas with the Chair and attendees.
b) Preparation, collation and circulation of papers in good time.
c) Ensuring that those invited to each meeting attend, highlighting any concerns to Chair (including interests of members that may conflict with an agenda item).
d) Taking the minutes and helping the Chair to prepare any necessary reports to the Partners' Boards.
e) Keeping a record of matters arising and issues to be carried forward.
f) Maintaining records of members' appointments and renewal dates.
g) Ensuring that action points are taken forward between meetings.
h) Ensuring that members receive the development and training they need.

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i) Providing appropriate support to the Chair and members.

7.8 Following each meeting of the Committee, the administrator will also:

a) Maintain an attendance log and follow up as appropriate after each meeting to ensure the Committee adheres to the required frequency of attendance by members; and
b) Maintain a decisions log of reporting arrangements into each formal meeting of the Committee.

8. Review of Terms of Reference

8.1 The Terms of Reference will be reviewed annually or earlier if required. Any proposed amendments will be submitted to the SWP Board for approval.

Document Control

Document Reference	SWPCEEC ToR
Version	V.1.1
Senior Responsible Officer	Philippa Harding, Company Secretary,
Author/s	Head of Corporate Governance
Approval by	South West Peninsula Board
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Change Record

Date	Version	Comments
19.03.26	V0.1	Annual Committee Review. Document Control template amended. Membership Updated

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NHS Cornwall and Isles of Scilly

NHS Devon

Enter meeting name here

Enter report title here

Date of meeting	Date report produced
Insert date of meeting at which report is due to be considered	Insert date of initial submission to Chief Officer for approval

Author(s)		Report approved by	
Name and title:	Insert name and title of report author(s)	**Name and title:**	Insert name and title of Chief Officer(s) approving the report

Executive summary
Insert a high level summary of the report, including the rationale for any recommendations. This should be no more than 500 words.

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
Insert any reasons for confidentiality, according to the Freedom of Information Act. The Governance team can assist with queries. Any reports not marked confidential will automatically be considered to be appropriate for publication.

What is the purpose of the report?	
ASSURANCE	☐
DECISION	☐

To which Board Assurance Framework risk does the report relate?
Insert the BAF risk to which the report relates, together with an explanation of how the content of the report provides assurance of risk mitigation/enables action to the taken to mitigate the risk. The Governance team can assist with queries.

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What are the recommendations arising from the report?
Insert the recommendations arising from the report, using one box per recommendation.
Guidance on recommendations can be found later in this template.

Has the issue been considered by any relevant groups previously? If so, what were the outcomes of that consideration?
Insert information about any related consideration by a relevant group, the meeting date, and a brief summary of the outcomes of that consideration

What are the implications of the matters covered in this report for the following areas?	
Area	
Residents and Communities	Insert any implications that the matters covered in the report might have for residents and communities. If no implications, then please state this explicitly.
Quality and Safety	Insert any implications that the matters covered in the report might have for quality and safety. If no implications, then please state this explicitly.
Equality, Diversity and Inclusion	Insert any implications that the matters covered in the report might have for equality, diversity and inclusion. If no implications, then please state this explicitly.
Finances and Use of Resources	Insert any implications that the matters covered in the report might have for finance and use of resources. If no implications, then please state this explicitly.
Regulation and Legal Requirements	Insert any implications that the matters covered in the report might have for regulation and legal requirements. If no implications, then please state this explicitly.
Information Governance (DP and Cyber)	Insert any implications that the matters covered in the report might have for information governance. If no

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	implications, then please state this explicitly.
Transformation and Innovation	Insert any implications that the matters covered in the report might have for transformation and innovation. If no implications, then please state this explicitly.
Environment and Climate Change	Insert any implications that the matters covered in the report might have for the environment and climate change. If no implications, then please state this explicitly.

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Enter report title here

Introduction and background

1. What is the issue? Provide a brief explanation of what your report is about, why it is being presented and what the rest of the report will include. This should not be a copy of the Executive Summary.

2. Include any context which would be useful for the meeting and a summary of the "story so far"?

Section headings as required

3. Follow the paragraph numbering throughout the report – do not number sections.

Subheadings as required

4. Follow the paragraph numbering throughout the report – do not number sections.

Next Steps

5. Follow the paragraph numbering throughout the report – do not number sections.

   Outline here the actions anticipated to follow the Board /Committees' consideration, including future committee consideration and/or details of how actions will be implemented and monitored, and by whom. Please highlight any dates or deadlines that are critical to the decision and/or its implementation.

Conclusion

6. This should be the final section of your report. List the recommendations included on the cover sheet of the report. These should be identical.

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Levels of Assurance				
	Significant	**Satisfactory**	**Limited**	**None**
Definition	The Board/Committee can take robust assurance that the system of control achieves or will achieve the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	The Board/Committee can take sufficient assurance that controls upon which the organisation relies to manage the risk(s) are in the main suitably designed and effectively applied. There remains a moderate amount of residual risk.	The Board/Committee can take some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk which requires action to be taken.	The Board/Committee cannot take any assurance from the information that has been provided. There remains a significant amount of residual risk.
Examples of when assurance level applies	• The purpose is quite narrowly defined, and it is relatively easy to be comprehensively assured. • There is little evidence of system failure and the system appears to be both robust and sustainable. • The Board/Committee is provided with evidence from several different sources to support its conclusion. External sources of corroboration (audit reports etc.) are especially useful.	• In most respects the "purpose" is being achieved • There are some areas where further action is required, and the residual risk is greater than "insignificant". • Where the report includes a proposed remedial action plan, the Board/Committee considers it to be credible and acceptable	• There are known material weaknesses in key areas. • It is known that there will have to be changes to the system (e.g. due to a change in the law) and the impact has not been assessed and planned for. • The report has provided incomplete information, and not covered the whole purpose of the agenda item. • The proposed action plan to address areas of identified residual risk is not comprehensive or credible or deliverable.	• Immediate action is required to address fundamental gaps, weaknesses or non-compliance. • The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area in question. • There has been a significant breakdown in the application of internal controls
Action to be taken	If no issues at all, may not require a further report until the next scheduled periodic review of the subject, or if circumstances materially change.	The Board/Committee will ask the relevant Executive to provide assurance at an agreed later date that the remedial actions have been completed. The timescale for this assurance will depend on the level of residual risk.	The Board/Committee will ask the relevant Executive to provide a further paper at its next meeting, and will monitor the situation until it is satisfied that the level of assurance has been improved.	The relevant Executive will provide a further paper at its next meeting, and the Board/Committee will monitor the situation until it is satisfied that the level of assurance has been improved.

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Decisions				
	Approve	**Agree**	**Endorse**	**Note**
Definition	This is a request for the Board to exercise its formal authority to authorise a decision. The Board takes full governance ownership; it will have legal responsibility for the decision	This is a request for the Board to express a shared consensus. The Board is expressing full alignment on a specific point or principle before final details are worked through.	This is a request of support for an action, typically one where the Board is not the final decision-maker. The Board is expressing support for a proposed approach where the outcome of an action is not necessarily clear.	This is when a report is provided for information only and requires no decision or formal action from the Board. The Board is confirming that it has received and read the information.
Examples of when decision should be requested	• Budgets • Significant contracts • Policy changes • Meeting minutes/official records	• Points of principle • Strategy development	• Often used by **committees** who lack the authority to approve a final decision but want to recommend it to the full Board for their approval.	• CEO updates • Regular monitoring reports • Minor operational change

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