NHS North Central London Integrated Care Board

Constitution

Version Control:

Version	Author	Amendments	Effective Date
1	Andrew Spicer, Head of Governance and Risk- North Central London Clinical Commissioning Group	Creation of the Constitution.	1st July 2022

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Commented [SA1]: Will finalise once Constitution is fully drafted.

CONSTITUTION

1. NAME

1.1 The name of this Integrated Care Board is NHS North Central London Integrated Care Board ('ICB').

2. AREA COVERED BY THE INTEGRATED CARE BOARD

2.1 The area covered by the ICB is the geographical boundaries of the London Boroughs of Barnet, Camden, Enfield, Haringey and Islington. **[ADS- Will need to be as per the Establishment Order]**

3. STATUTORY FRAMEWORK

3.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

3.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

3.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

3.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29). This constitution is published on the ICB's website.

3.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 1989 and section 14Z32 of the 2006 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) Duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014);
d) Adult safeguarding and carers (the Care Act 2014);
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35);
f) Information law, (for instance, data protection laws, such as the EU General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000);
g) Provisions of the Civil Contingencies Act 2004.

3.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

3.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:

a) Section 14Z34 (improvement in quality of services);
b) Section 14Z35 (reducing inequalities);
c) Section 14Z38 (obtaining appropriate advice);
d) Section 14Z43 (duty to have regard to effect of decisions);
e) Section 14Z44 (public involvement and consultation);
f) Sections 223GB to 223N (financial duties); and
g) Section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

3.8 NHS England has powers to obtain information from the ICB (section 14Z58 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z59).

4. STATUS OF THIS CONSTITUTION

4.1 The ICB was established on 1st July 2022 by [*name and reference of establishment order*], which made provision for its constitution by reference to this document.

4.2 This document is the constitution of the ICB ('Constitution').

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

5. VARIATION OF THIS CONSTITUTION

5.1 In accordance with paragraph 14 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) Where the ICB applies to NHS England in accordance with NHS England's published procedure[6] and that application is approved; and
b) Where NHS England varies the Constitution of its own initiative (other than on application by the ICB).

5.2 The procedure for proposal and agreement of variations to the Constitution is as follows:[7]

a) Anyone may propose a variation or amendment to the Constitution;
b) Proposed variations or amendments to this Constitution must be submitted to the ICB's Governance and Risk Team for consideration;
c) The Executive Director of Corporate Affairs, in consultation with the ICB's Governance and Risk Team, may accept or reject any proposed variation or amendment to the Constitution at his or her absolute discretion and without creating any precedents for any further or future decisions;
d) The Executive Director of Corporate Affairs shall consult with the Governance and Risk Team, Chair and Chief Executive of the ICB Board and the Audit Committee Chair prior to any amendments or variations to the Constitution being submitted to the ICB Board for approval;
e) Prior to making an application to NHS England in accordance with section 5.1(a) above any proposed variations or amendments to the Constitution must be approved by the ICB Board. Any motion will be passed by a simple majority of those Board members voting;
f) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

6. RELATED DOCUMENTS

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

6.2 The following are appended to the Constitution and form part of it for the purpose of section 5 and the ICB's legal duty to have a constitution:

a) **Standing Orders–** which set out the arrangements and procedures to be used for meetings and the selection and appointment processes for the ICB Committees.

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

a) **The Scheme of Reservation and Delegation ('SORD')**[8]**–** sets out those decisions that are reserved to the ICB Board and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SORD identifies where, or to whom, functions and decisions have been delegated;

b) **Functions and Decision Map**[9]**-** This is a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision Map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England);

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

d) **The ICB Governance Handbook**[10]**–** which includes:

- The ICB's Constitution;
- Terms of reference for all Committees and Sub-Committees of the Board that exercise ICB functions[11];
- Delegation arrangements[12] for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another Integrated Care Board, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act;
- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act;
- The SORD;
- The Functions and Decisions Map;
- The Standing Financial Instructions;
- Corporate Governance and Risk Management policies.

e) **Key policy documents**[13] **-** including:

- Standards of Business Conduct Policy;
- Conflicts of interest policy and procedures;
- Speaking Up (Whistleblowing) Policy;
- Policy for public involvement and engagement.

7. MEMBERSHIP OF THE ICB

7.1 This section 7 of the Constitution describes the membership of the ICB. Further information about the criteria for the roles and how they are appointed is in sections 12 to 21 below.

7.2 Further information about the individuals who fulfil these roles can be found on the ICB's website.

7.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act the membership of the ICB consists of:

a) A Chair;
b) A Chief Executive;
c) At least three Ordinary members.

7.4 The Ordinary[15] Members must include at least three members who will bring knowledge and a perspective from their sectors. These members (known as 'Partner Members') are identified and appointed in accordance with the procedures set out in sections 10, 11, 14, 15 and 16 below and are from:

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

7.5 The ICB has agreed to appoint an additional Partner Member from the UCL Health Alliance. This Partner Member is identified and appointed with the procedures set out in section 17 below.

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

7.7 NHS England Policy[17] requires the ICB to appoint the following additional Ordinary Members:

a) Three executive members as follows:
   - Director of Finance;
   - Medical Director;
   - Director of Nursing;
b) At least two[18] Independent Non-Executive Members.

8. BOARD OF MEMBERS

8.1 The membership of the ICB shall meet as a unitary board. This Board of Members is referred to in this Constitution as the 'Board'. The Board is comprised solely of members of the ICB. Membership, eligibility, disqualification and removal from office as per sections 7, 8, 10, 11, and 22 of the Main Body of the Constitution and any terms of appointment refer to both membership of the ICB and membership of the Board.

8.2 The ICB has 6[16] Partner Members:

a) Two Partner Members- NHS Trusts and Foundation Trusts;
b) Two Partner Member- Providers of Primary Medical Services;
c) Partner Member- Local Authorities;
d) Partner Member- UCL Health Alliance.[19]

8.3 The ICB Board is therefore composed of the following 13 members:

a) Chair;
b) Chief Executive;
c) Two Partner Members- NHS Trusts and Foundation Trusts;
d) Two Partner Member- Providers of Primary Medical Services;
e) Partner Member- Local Authorities;
f) Partner Member- UCL Health Alliance
g) Two Independent Non-Executive Members;
h) Director of Finance;
i) Medical Director;
j) Director of Nursing.

8.4 The four executive members referred to in clauses 7.3, 7.7 and 8.3 above describe the required statutory roles rather than the specific job titles of officers holding those roles. For example, the ICB may call the Director of Finance the Chief Finance Officer. The Chief Finance Officer role would incorporate the mandated Director of Finance role.

9. PARTICIPANTS AND OBSERVERS AT BOARD MEETINGS[20]

9.1 The Board shall invite other members of the ICB's executive management team, representatives from Public Health, Adult Social Care and Children's Social Care to attend all or part of its meetings at its absolute discretion as standing participants.

9.2 The standing participants referred to in section 9.1 above are non-voting.

9.3 The Board may invite or allow additional people to attend Board meetings, or part of meetings, as participants in order to assist it in its decision-making and in its discharge of its functions as it sees fit. Participants may present at Board meetings and contribute to relevant discussions but are not allowed to participate in any formal vote.

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

9.5 The Board may call additional experts to attend meetings on a case by case basis to inform discussions.

10. ELIGIBILITY CRITERIA FOR BOARD MEMBERSHIP

10.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test";[24]
b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles);
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

11. DISQUALIFICATION CRITERIA FOR BOARD MEMBERSHIP[25]

11.1 The following individuals are automatically disqualified from being a member of the ICB Board:

a) A Member of Parliament, or member of the London Assembly;

b) A member of a local authority in England and Wales or of an equivalent body in Scotland or Northern Ireland;

c) A person whose involvement with the private healthcare sector or otherwise could reasonably be deemed to risk undermining the independence of the NHS;

Commented [SA2]: There is a proposal to have an elected Local Authority Councillor as an ICB Board member. We are awaiting the outcome from national conversations. Our strong preference is for this to be a Leader of a Local Authority.

d) A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted—
   - in the United Kingdom of any offence, or
   - outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine;

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

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

g) A person whose term of appointment as the chair, a member, a director or a governor of a health service body, has been terminated on the grounds:
   - That it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office; and/or
   - That the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings; and/or
   - That the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest; and/or
   - of misbehaviour, misconduct or failure to carry out the person's duties;

h) A health care professional (within the meaning of section 14N of the 2006 Act) or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was—
   - The person's suspension from a register held by the regulatory body, where that suspension has not been terminated; and/or
   - The person's erasure from such a register, where the person has not been restored to the register; and/or
   - A decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded; and/or
   - A decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

i) A person who is subject to—
   - A disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002; and/or
   - An order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual);

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

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

12. CHAIR[26]

12.1 The ICB Chair[27] is to be appointed by NHS England, with the approval of the Secretary of State.

12.2 In addition to criteria specified at clause 10.1 above, this member must fulfil the following additional eligibility criteria:
a) The Chair will be independent.

12.3 Individuals will not be eligible if:
a) They hold a role in another health and care organisation within the ICB area;
b) Any of the disqualification criteria set out in section 11 above apply.

12.4 The term of office of the Chair will be three years and the total number of terms a Chair may serve is two terms, subject to the provisions of the Standing Orders.

13. CHIEF EXECUTIVE

13.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.[29]

13.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.[30]

13.3 The Chief Executive must fulfil the following additional eligibility criteria:
a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act. [31]

13.4 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in section 11 above apply;
b) Subject to clause 13.3(a), they hold any other employment or executive role.

14. TWO PARTNER MEMBERS- NHS TRUSTS AND FOUNDATION TRUSTS [add which[32] NHS Trusts and FTs provide services within the ICB area]

14.1 These Partner Members are nominated by the NHS statutory partners which provide services within the area and are of a *description to be inserted in accordance with the regulations*[33]. The partners which may nominate these Partner Members are:

a) Barnet, Enfield and Haringey Mental Health NHS Trust;
b) Camden and Islington NHS Foundation Trust;
c) Central and North West London NHS Foundation Trust;
d) Central London Community Healthcare NHS Trust;
e) Great Ormond St Hospital for Children NHS Foundation Trust;
f) Moorfields Eye Hospital NHS Foundation Trust;
g) North Middlesex University Hospital NHS Trust;
h) Royal National Orthopaedic Hospital NHS Trust;
i) Tavistock and Portman NHS Foundation Trust;
j) The Royal Free London NHS Foundation Trust;
k) University College London Hospitals NHS Foundation Trust;
l) Whittington Health NHS Trust.

Commented [SA3]: We are awaiting further clarity from either the legislation or the national guidance on which organisations are included (e.g. CNWL and LAS).

14.2 These members must fulfil the eligibility criteria set out at 10.1 above and also the following additional eligibility criteria:
a) Be an executive director of one or more of the NHS trusts or foundation trusts within the ICB's area.[34]

Commented [SA4]: Our preference is for this to be either a Chair, Non-Executive Director or an Executive Director but national guidance states it should be an Executive Director.

14.3 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in section 11 above apply.

14.4 These members will be appointed by[35] an ICB appointments panel subject to the approval of the Chair;

14.5 The appointment process will be as follows[36]:
a) The NHS trusts and foundation trusts set out in clause 14.1 above have delegated their authority to jointly agree which candidates to nominate to the Board of the UCL Health Alliance;
b) The Board of the UCL Health Alliance shall agree which candidates to nominate, ensuring that any such candidates meet the requirements of the role based on a role specification produced by the ICB;
c) The Board of the UCL Health Alliance will sign a letter addressed to the Chair of the ICB containing their list of nominated candidates and a statement confirming that the nominated candidates meet the requirements of the role. The letter will be sent to the Chair and Chief Executive of the ICB;
d) The ICB appointments panel referred to in clause 14.4 above shall consider the list. It shall undertake a shortlisting process and interview any shortlisted candidates;
e) If the ICB appointments panel considers at either the shortlisting or interview stage that none of the candidates nominated by the Board of the UCL Health Alliance are suitable the nominated candidates shall be rejected and the nominations process will restart;
f) If the ICB appointments panel considers that at least one of the candidates has the skills, knowledge, experience and attributes required to fulfil the role and is therefore suitable it shall make a recommendation to the Chair of the ICB as to which candidate to appoint. The Chair of the ICB shall approve or not approve the recommendation at his or her absolute discretion and without creating a precedent for any further or future decisions;
g) If the Chair of the ICB approves the recommendation the recommended candidate shall be appointed. If the Chair of the ICB does not approve the recommendation the ICB appointments panel shall reconsider its recommendation and shall either recommend another suitable candidate to the Chair of the ICB or if there are no suitable candidates the candidates shall be rejected and the nominations process will restart.

Commented [SA5]: This proposed appointments process is still to be confirmed following the engagement process with partners and key stakeholders.

14.6 The term of office[37] for these Partner Members will be three years and the total number of terms they may serve is two terms, subject to the provisions of the Standing Orders.

15. TWO PARTNER MEMBERS- PROVIDERS OF PRIMARY MEDICAL SERVICES

15.1 These Partner Members are nominated by providers of primary medical services for the purposes of the health service within the Integrated Care Board's area, and are *description to be inserted in accordance with the regulations*].

15.2 These members must fulfil the eligibility criteria set out at 10.1 above and also the following additional eligibility criteria:

a) One Partner Member must be able to bring a sector perspective of the North of North Central London. One Partner Member must be able to bring a sector perspective of the South of North Central London. This is to ensure the ICB Board has a broad range of perspectives from Primary Care covering its entire geography. [38]

15.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in section 11 above apply.

15.4 These members will be appointed by[39] an ICB appointments panel subject to the approval of the Chair.

15.5 The appointment process will be as follows[40]:

a) The providers of primary medical services set out in clause 15.1 above have delegated their authority to jointly agree which candidates to nominate to the Board of the North Central London GP Provider Alliance ('GP Provider Alliance');

b) The Board of the GP Provider Alliance shall agree which candidates to nominate, ensuring that any such candidates meet the requirements of the role based on a role specification produced by the ICB;

c) The Board of the GP Provider Alliance will sign a letter addressed to the Chair of the ICB containing their list of nominated candidates and a statement confirming that the nominated candidates meet the requirements of the role. The letter will be sent to the Chair and Chief Executive of the ICB;

d) The ICB appointments panel referred to in clause 15.4 above shall consider the list. It shall undertake a shortlisting process and interview any shortlisted candidates;

e) If the ICB appointments panel considers at either the shortlisting or interview stage that none of the candidates nominated by the Board of the GP Provider Alliance are suitable the nominated candidates shall be rejected and the nominations process will restart;

f) If the ICB appointments panel considers that at least one of the candidates has the skills, knowledge, experience and attributes required to fulfil the role and is therefore suitable it shall make a recommendation to the Chair of the ICB as to which candidate to appoint. The Chair of the ICB shall approve or not approve the recommendation at his or her absolute discretion and without creating a precedent for any further or future decisions;

g) If the Chair of the ICB approves the recommendation the recommended candidate shall be appointed. If the Chair of the ICB does not approve the recommendation the ICB appointments panel shall reconsider its recommendation and shall either recommend another suitable candidate to the Chair of the ICB or if there are no suitable candidates the candidates shall be rejected and the nominations process will restart.

15.6 The terms of office[41] for these Partner Members will be three years and the total number of terms they may serve is two terms, subject to the provisions of the Standing Orders.

16. PARTNER MEMBER- LOCAL AUTHORITIES

Commented [SA6]: This proposed appointments process is still to be confirmed following the engagement process with partners and key stakeholders.

16.1 This Partner Member is nominated by the local authorities whose areas coincide with, or include the whole or any part of, the Integrated Care Board's area. Those local authorities are:

a) Barnet London Borough Council;
b) Camden London Borough Council;
c) Enfield London Borough Council;
d) Haringey London Borough Council;
e) Islington London Borough Council.

16.2 This member will fulfil the eligibility criteria set out at 10.1 above.

16.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in section 11 above apply.

16.4 This member will be appointed by[42] an ICB appointments panel subject to the approval of the Chair.

16.5 The appointment process will be as follows[43]:

a) The local authorities set out in clause 16.1 above shall jointly agree which candidates to nominate, ensuring that any such candidates meet the requirements of the role based on a role specification produced by the ICB;
b) These local authorities will jointly sign a letter addressed to the Chair of the ICB containing their list of nominated candidates and a statement confirming that the nominated candidates meet the requirements of the role. The letter will be sent to the Chair and Chief Executive of the ICB;
c) The ICB appointments panel referred to in clause 16.4 above shall consider the list. It shall undertake a shortlisting process and interview any shortlisted candidates;
d) If the ICB appointments panel considers at either the shortlisting or interview stage that none of the candidates nominated by the local authorities are suitable the nominated candidates shall be rejected and the nominations process will restart;
e) If the ICB appointments panel considers that at least one of the candidates has the skills, knowledge, experience and attributes required to fulfil the role and is therefore suitable it shall make a recommendation to the Chair of the ICB as to which candidate to appoint. The Chair of the ICB shall approve or not approve the recommendation at his or her absolute discretion and without creating a precedent for any further or future decisions;
f) If the Chair of the ICB approves the recommendation the recommended candidate shall be appointed. If the Chair of the ICB does not approve the recommendation the ICB appointments panel shall reconsider its recommendation and shall either recommend another suitable candidate to the Chair of the ICB or if there are no suitable candidates the candidates shall be rejected and the nominations process will restart.

16.6 The term of office[44] for this Partner Member will be three years and the total number of terms they may serve is two terms, subject to the provisions of the Standing Orders.

17. PARTNER MEMBER- UCL HEALTH ALLIANCE [61]

17.1 This Partner Member is nominated by the UCL Health Alliance.

17.2 This member must fulfil the eligibility criteria set out at 10.1 above and also the following additional eligibility criteria:

a) Be a Chair, Non-Executive Director or an executive director of one or more of the NHS Trusts or FTs within the ICB's area or be a director, partner, employee, salaried or a

Commented [SA7]: This proposed appointments process is still to be confirmed following the engagement process with partners and key stakeholders.

sessional GP at one or more of the GP practices or GP federations within the ICB's area; and

b) Be a member of the board of the UCL Health Alliance.

17.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in section 11 above apply.

17.4 These members will be appointed by[35] an ICB appointments panel subject to the approval of the Chair.

17.5 The appointment process will be as follows[36]:

a) The Board of the UCL Health Alliance shall agree which candidates to nominate, ensuring that any such candidates meet the requirements of the role based on a role specification produced by the ICB;

b) The Board of the UCL Health Alliance will sign a letter addressed to the Chair of the ICB containing their list of nominated candidates and a statement confirming that the nominated candidates meet the requirements of the role. The letter will be sent to the Chair and Chief Executive of the ICB;

c) The ICB appointments panel referred to in clause 17.4 above shall consider the list. It shall undertake a shortlisting process and interview any shortlisted candidates;

d) If the ICB appointments panel considers at either the shortlisting or interview stage that none of the candidates nominated by the Board of the UCL Health Alliance are suitable the nominated candidates shall be rejected and the nominations process will restart;

e) If the ICB appointments panel considers that at least one of the candidates has the skills, knowledge, experience and attributes required to fulfil the role and is therefore suitable it shall make a recommendation to the Chair of the ICB as to which candidate to appoint. The Chair of the ICB shall approve or not approve the recommendation at his or her absolute discretion and without creating a precedent for any further or future decisions;

f) If the Chair of the ICB approves the recommendation the recommended candidate shall be appointed. If the Chair of the ICB does not approve the recommendation the ICB appointments panel shall reconsider its recommendation and shall either recommend another suitable candidate to the Chair of the ICB or if there are no suitable candidates the candidates shall be rejected and the nominations process will restart.

17.6 The term of office for this Partner Member will be three years and the total number of terms they may serve is two terms, subject to the provisions of the Standing Orders.

18. MEDICAL DIRECTOR [45]

18.1 This member will fulfil the eligibility criteria set out at 10.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB[46] or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act;

b) Be a registered Medical Practitioner.

18.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in section 11 above apply.

18.3 This member will be appointed by[47] the Chief Executive subject to the approval of the Chair.

19. DIRECTOR OF NURSING [48]

Commented [SA8]: This proposed appointments process is still to be confirmed following the engagement process with partners and key stakeholders.

19.1 This member will fulfil the eligibility criteria set out at 10.1 above and also the following additional eligibility criteria:

a) Be an employee[49] of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act;
b) Be a registered Nurse.

19.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in section 11 above apply.

19.3 This member will be appointed by[50] the Chief Executive subject to the approval of the Chair.

20. DIRECTOR OF FINANCE [51]

20.1 This member will fulfil the eligibility criteria set out at 10.1 above and also the following additional eligibility criteria:

a) Be an employee of the ICB[52] or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act.

20.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in section 11 above apply.

20.3 This member will be appointed by[53] the Chief Executive subject to the approval of the Chair.

21. TWO[4] INDEPENDENT NON-EXECUTIVE MEMBERS [55]

21.1 The ICB will appoint two Independent Non-Executive Members.

21.2 These members will be appointed by[56] an ICB appointments panel subject to the approval of the Chair. The appointments panel shall include, as a minimum, at least three people as follows:

a) The Chair of the Board;
b) Two representatives from ICB partner organisations.

21.3 These members will fulfil the eligibility criteria set out at 10.1 above and also the following additional eligibility criteria:

a) Not be an employee of the ICB or a person seconded to the ICB;
b) Not hold a role in another health and care organisation in the ICS area;
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee;
d) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee.[57]

21.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in section 11 above apply;
b) They hold a role in another health and care organisation within the ICB area.

21.5 The term of office for an Independent Non-Executive Member will be three years and the total number of terms an individual may serve is two[58] terms after which they will no longer be eligible for re-appointment, subject to the provisions of the Standing Orders.

21.6 Initial appointments may be for a shorter period at the ICB Chair's absolute discretion and without setting any precedents for any future decision [59] in order to avoid all non-executive

members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.

21.7 Subject to[60] satisfactory appraisal the Chair may approve the re-appointment of an Independent Non-Executive Member for additional terms of office up to the maximum number of years permitted for their role as set out in clause 21.5 above.

22. BOARD MEMBERS: REMOVAL FROM OFFICE

22.1 Arrangements for the removal from office of Board members is subject to the term of appointment, and application of the relevant ICB policies and procedures.

22.2 With the exception of the Chair and Executive Directors, ICB Board members shall be removed from office, after following a fair process, if any of the following occurs:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance;
b) If they fail to attend three ICB Board meetings in a row without the permission of the Chair;
c) A motion of no confidence is passed by a simple majority of ICB Board members. The simple majority must include the Chair of the Board or the Deputy Chair if the Chair is unable to participate in any vote due to a conflict of interest;
d) If their behaviour, conduct and/or professionalism:
    - Falls below the standard required for the role;
    - Brings the ICB and/or the ICB Board into disrepute;
    - Is dishonest, an abuse of position, professional misconduct or grossly negligent;
e) If for some other substantial reason their position has become untenable. [62]

22.3 The Executive Director members of the ICB Board shall be removed from office if any of the following occurs:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance;
b) If their employment with the ICB is terminated.

22.4 For Executive Director Members of the ICB Board they shall only be removed upon the outcome of the ICB's HR disciplinary process. Grounds for triggering the ICB's disciplinary process may include:

a) If they fail to attend three ICB Board meetings in a row without the permission of the Chair;
b) In the event of performance concerns a motion of no confidence is passed by a simple majority of ICB Board members. The simple majority must include the Chair of the Board or the Deputy Chair if the Chair is unable to participate in any vote due to a conflict of interest;
c) If their behaviour, conduct and/or professionalism:
    - Falls below the standard required for the role;
    - Brings the ICB and/or the ICB Board into disrepute;
    - Is dishonest, an abuse of position, professional misconduct or grossly negligent;
d) If for some other substantial reason their position has become untenable.

22.5 Members may be suspended pending the outcome of an investigation into whether any of the matters in 22.2, 22.3 and/or 22.4 above apply.

22.6 Executive Directors (including the Chief Executive) will cease to be Board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

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

22.8 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

a) Terminate the appointment of the ICB's Chief Executive; and
b) Direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

23. TERMS OF APPOINTMENT OF BOARD MEMBERS

23.1 With the exception of the Chair of the ICB arrangements for remuneration[63] and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy, any other relevant policies published on the ICB's website and any guidance issued by NHS England or other relevant body.

23.2 Remuneration for the Chair of the ICB will be set by NHS England. [63]

23.3 Other terms of appointment for Board members will be determined by the Remuneration Committee.

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

24. GOOD GOVERNANCE

24.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.

24.2 The ICB has agreed a code of conduct and behaviours [64] which sets out the expected behaviours that members of the Board and its Committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB code of conduct and behaviours is published in the Governance Handbook.

25. GENERAL

25.1 The ICB will:

a) Comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;
b) Comply with directions issued by the Secretary of State for Health and Social Care;
c) Comply with directions issued by NHS England;
d) Have regard to statutory guidance including that issued by NHS England;
e) Take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England;
f) Respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

25.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(e) above, documenting them as necessary in this Constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

26. AUTHORITY TO ACT

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

a) Any of its members or employees;
b) A Committee or Sub-Committee of the ICB.

26.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

26.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the Board must authorise the arrangement, which must be described as appropriate in the SORD.

27. SCHEME OF RESERVATION AND DELEGATION

27.1 The ICB has agreed a Scheme of Reservation and Delegation ('SORD') which is published in full on the ICB's website.

27.2 Only the Board may agree the SORD and amendments to the SORD may only be approved by the Board.

27.3 The SORD sets out:

a) Those functions that are reserved to the Board;
b) Those functions that have been delegated to an individual or to Committees and sub committees;
c) Those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.

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

28. FUNCTIONS AND DECISIONS MAP

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

28.2 The Functions and Decision Map is published on the ICB's website.

28.3 The Functions and Decisions Map includes:

a) Key functions reserved to the Board of the ICB;
b) Commissioning functions delegated to Committees and individuals;
c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body;
d) Functions delegated to the ICB (for example, from NHS England).

29. COMMITTEES AND SUB-COMMITTEES [65]

29.1 The ICB may appoint Committees and arrange for its functions to be exercised by such Committees. Each Committee may appoint Sub-Committees and arrange for the functions exercisable by the Committee to be exercised by those Sub-Committees at the Board's absolute discretion.

29.2 All Committees and Sub-Committees are listed in the SORD.

29.3 Each Committee and Sub-Committee established by the ICB operates under Terms of Reference and membership agreed by the Board [66]. All Terms of Reference are published in the Governance Handbook.

29.4 The Board remains accountable for all functions, including those that it has delegated to Committees and subcommittees and therefore, appropriate reporting and assurance arrangements are in place and documented in Terms of Reference. All Committees and Sub-Committees that fulfil delegated functions of the ICB, will be required to:

a) Discharge their functions effectively and from within their delegated authorities;
b) Provide reports to the Board as required. [67]

29.5 Any Committee or Sub-Committee established in accordance with this section 29 may consist of, or include, persons who are not ICB Members or employees.

29.6 All members of Committees and Sub-Committees are required to act in accordance with this Constitution, including the Standing Orders as well at the SFIs and any other relevant ICB policy.

29.7 The following Committees will be maintained:

a) **Audit Committee**[68]**:** This committee is accountable to the Board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit Committee will be chaired by an Independent Non-Executive Member (other than the Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration Committee**[69]**:** This committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) and terms of service for a) Board members (other than the Chair of the ICB), b) ICB officers, c) clinical leads and d) employees at the Very Senior Manager level. It also sets the employee pay policy for employees below the Very Senior Manager level.

The Remuneration Committee will be chaired by an Independent Non-Executive Member other than the Chair or the Chair of Audit Committee.

29.8 The terms of reference for each of the above Committees are published in the Governance Handbook[70].

29.9 The Board has also established a number of other Committees to assist it with the discharge of its functions. These Committees are set out in the SORD and further information about these Committees, including terms of reference, are published[71] in the Governance Handbook.

30. DELEGATIONS MADE UNDER SECTION 65Z5 OF THE 2006 ACT

30.1 As per 26.2 above the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

30.2 All delegations made under these arrangements are set out in the ICB SORD and included in the Functions and Decision Map.

30.3 Each delegation made under section 65Z5 of the 2006 Act will be set out in a delegation arrangement which sets out the terms of the delegation[72]. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the Board.

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

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

31. STANDING ORDERS

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

a) Conducting the business of the ICB;
b) The procedures to be followed during meetings; and
c) The process to delegate functions.

31.2 The Standing Orders apply to all Committees and Sub-Committees of the ICB unless specified otherwise in in Standing Orders or in terms of reference which have been agreed by the Board.

31.3 A full copy of the Standing Orders[74] is included in Appendix 2 and form part of this Constitution.

32. STANDING FINANCIAL INSTRUCTONS

32.1 The ICB has agreed a set of Standing Financial Instructions ('SFIs') which include the delegated limits of financial authority set out in the SORD.

32.2 A copy of the SFIs published in the Governance Handbook on the ICB's website.

33. CONFLICTS OF INTEREST [75]

[DN: subject to change in line with NHS England guidance[76]]

33.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

33.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the ICB's website. [77]

33.3 All Board, Committee and Sub-Committee members, officers and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or

employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

33.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

33.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of interest Policy and the Standards of Business Conduct Policy. [78]

33.6 The ICB has appointed the Audit Committee Chair to be the Conflicts of Interest Guardian. [79] In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public, healthcare professionals and wider Integrated Care System partners who have any concerns with regards to conflicts of interest;
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
c) Support the rigorous application of conflict of interest principles and policies;
d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
e) Provide advice on minimising the risks of conflicts of interest.

34. PRINICPLES FOR CONFLICT OF INTEREST MANAGEMENT [80]

Commented [SA9]: We are awaiting further guidance from NHS England which is expected in February 2022.

34.1 In discharging its functions the ICB will abide by the following principles:

a) Xxx
b) Xxx

35. DECLARING AND REGISTERING INTERESTS

35.1 The ICB maintains registers[81] of the interests of:

a) Members of the ICB;
b) Members of the Board's Committees and Sub-Committees;
c) Its employees.

35.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB's website. [82]

35.3 All relevant persons as per 33.3 and 33.5 above must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

35.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

35.5 All relevant declarations will be entered in the registers as per 35.1 above.

35.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

35.7 Interests [83] (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

35.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

36. STANDARDS OF BUSINESS CONDUCT

36.1 Board members, employees, Committee and Sub-Committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) Act in good faith and in the interests of the ICB;
b) Follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);
c) Comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

36.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

37. ACCOUNTABLILITY AND TRANSPARENCY

37.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 11(2) of Schedule 1B to the 2006 Act.

38. TRANSPARENCY PRINCIPLES [84]

38.1 Add local principles

Commented [SA10]: We would value from NHS England any good practice content for this section from other ICBs for our consideration.

39. MEETINGS AND PUBLICATIONS

39.1 ICB Board and Committee meetings will be held in public except:

a) Where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest in accordance with section 17 of the Standing Orders;
b) The Audit Committee and the Remuneration Committee shall not be held in public.

39.2 Papers and minutes of all meetings held in public will be published.

39.3 Annual accounts will be externally audited and published.

39.4 A clear complaints process will be published.

39.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

39.6 Information will be provided to NHS England as required.

39.7 The Constitution and Governance Handbook will be published as well as other key documents including but not limited to:

a) Conflicts of interest policy and procedures;
b) Registers of interests; [85]
c) Key policies.

39.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

a) Section 14Z34 (improvement in quality of services);
b) Section 14Z35 (reducing inequalities);
c) Section 14Z43 (have regard to effect of decisions);
d) Section 14Z44 (public involvement and consultation);
e) Sections 223H and 223J (financial duties).

39.9 The plan referred to in section 39.8 above shall also include proposed steps to implement the North Central London joint local health and wellbeing strategy(s)[86]

40. SCRUTINY AND DECISION MAKING

40.1 At least three Independent Non-Executive members will be appointed to the Board including the Chair. All of the Board and Committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

40.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

40.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including:

a) Publishing a procurement policy;
b) Ensuring arrangements are in place to appropriately publish information under the NHS provider Selection Regime in accordance with NHS England guidance on the ICB's website;
c) Ensuring arrangements are in place to appropriately manage conflicts of interest in line with NHS England guidance. [87]

40.4 The ICB will comply with local authority health overview and scrutiny requirements.

41. ANNUAL REPORT

41.1 The ICB will publish an annual report in accordance with any guidance published by NHS England which shall:

a) Set out how the ICB has discharged its functions and fulfilled its duties in the previous financial year and in particular how it has discharged its duties under sections:
   - 14Z34 (improvement in quality of services);
   - 14Z35 (reducing inequalities);
   - 14Z43 (have regard to the effect of decisions);
   - 14Z44 (public involvement and consultation);
b) Review the extent to which the ICB has exercised its functions in accordance with the plans published under sections:

- 14Z50 (Integrated Care System plan); and
- 14Z54 (capital resource use plan);

c) Review any steps the board has taken to implement any joint health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

42. ARRANGEMENTS FOR DETERMINING THE TERMS AND CONDITIONS OF EMPLOYEES

42.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

42.2 The Board has established a Remuneration Committee[88] which is chaired by a Non-Executive member other than the Chair or Audit Chair.

42.3 The membership of the Remuneration Committee is determined by the Board. No employees may be a member of the Remuneration Committee but the Board ensures that the Remuneration Committee has access to appropriate advice by:

a) Authorising the Remuneration Committee to obtain at the ICB's expense outside legal or other professional advice on any matter within the Remuneration Committee's Terms of Reference;
b) Members of the Governance and/or HR teams attending Remuneration Committee meetings to advise as appropriate.

42.4 The Board may appoint independent members or advisers to the Remuneration Committee who are not members of the Board.

42.5 The main purpose of the Remuneration Committee is to:

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

42.6 The duties of the Remuneration Committee are set out in its Terms of Reference. The Terms of Reference agreed by the Board are published in the Governance Handbook on the ICB's website. [89]:

42.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

43. ARRANGEMENTS FOR PUBLIC INVOLVEMENT

43.1 In line with section 14Z44(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) The planning of the commissioning arrangements by the Integrated Care Board;
b) The development and consideration of proposals by the ICB;
c) For changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to

the individuals (at the point when the service is received by them), or the range of health services available to them; and

d) Decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

43.2 In line with section 14Z52 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

a) The development of communication and engagement strategies and plans as appropriate;
b) The establishment of appropriate forums and channels of communication to effectively engage with the ICB's population;
c) The establishment of a Communications and Engagement Team;
d) The development of local principles to support the national principles developed by NHS England for working with people and communities;
e) The development of a transparent and open approach which considers and appropriately utilises feedback to shape our plan.

43.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities[90]:

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS;
b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions;
c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is working;
d) Build relationships with excluded groups – especially those affected by inequalities;
e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners;
f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust;
g) Use community development approaches that empower people and communities, making connections to social action;
h) Use co-production, insight and engagement to achieve accountable health and care services;
i) Co-produce and redesign services and tackle system priorities in partnership with people and communities;
j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

43.4 In addition the ICB[91] will develop a strategy for working with our communities which will include local engagement principles. These local engagement principles will build upon the ten principles set out in clause 43.4 above.

43.5 The principles set out in clauses 43.3 and 43.4 above will be used when developing and maintaining arrangements for engaging with people and communities.

43.6 These arrangements, include[92] [93]

a) Establishing a partnership forum which oversees resident engagement and involvement in the Integrated Care System;
b) Ensuring that the patient and resident voice is heard at a strategic level and that engagement insight is used to inform decision making and improve services;
c) Ensuring there is appropriate representation from key partners in engagement forums;
d) Establishing policies which supports the ICB's approach to community engagement, co-production, community power and placing local communities and their voices at the heart of the ICB's plans.

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
Board	The Board of Members comprising solely of members of the ICB as set out in sections 7 and 8 of the Main Body of the Constitution.
Area	The geographical area that the ICB has responsibility for, as defined in section 2 of this Constitution
Committee	A committee created and appointed by the ICB Board.
Executive Director	A member of the ICB's Executive Management Team.
Sub-Committee	A committee created and appointed by and reporting to a Committee.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Main Body of the Constitution	The Constitution excluding all Appendices.
Ordinary Member	The Board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the ICB, excluding the Chair and Chief Executive, are referred to as Ordinary Members.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.