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Leeds CITY COUNCIL

SCRUTINY BOARD (ADULTS, HEALTH AND ACTIVE LIFESTYLES) - REMOTE CONSULTATIVE MEETING

Consultative meeting to be held remotely* on
Tuesday, 26th April, 2022 at 11.30 am

(A pre-meeting will take place for ALL Members of the Board at 11.15 a.m.)

MEMBERSHIP

C Anderson	-	Adel and Wharfedale;
L Cunningham	-	Armley;
J Dowson	-	Chapel Allerton;
J Gibson	-	Cross Gates and Whinmoor;
N Harrington	-	Wetherby;
C Hart-Brooke	-	Rothwell;
M Iqbal	-	Hunslet and Riverside;
W Kidger	-	Morley South;
G Latty	-	Guiseley and Rawdon;
A Marshall-Katung (Chair)	-	Little London and Woodhouse;
E Taylor	-	Chapel Allerton;

Co-opted Member (Non-voting)

Dr J Beal - Healthwatch Leeds

Note to observers of the meeting: To remotely observe this meeting, please click on the 'To View Meeting' link which will feature on the meeting's webpage (linked below) ahead of the meeting. The webcast will become available at the commencement of the meeting.

https://democracy.leeds.gov.uk/ieListDocuments.aspx?CId=1190&MId=11809

*This is being held as a remote 'consultative' meeting. While the meeting will be webcast live to enable public access, it is not being held as a public meeting in accordance with the Local Government Act 1972.

Principal Scrutiny Adviser:
Angela Brogden
Tel: (0113) 37 88661

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**DECLARATION OF INTERESTS** To disclose or draw attention to any interests in accordance with Leeds City Council's 'Councillor Code of Conduct'.	
2			**UPDATE ON THE DEVELOPMENT OF THE LOCAL INTEGRATED CARE SYSTEM** To consider and discuss a report from the Head of Democratic Services which presents an update on the development of the local Integrated Care System.	3 - 104
3			**WORK SCHEDULE** To consider and discuss the Scrutiny Board's work schedule for the 2021/22 municipal year and draft work schedule for the 2022/23 municipal year.	105 - 124

Third Party Recording

Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda.

Use of Recordings by Third Parties– code of practice

a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title.
b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.

Webcasting

Please note – the publicly accessible parts of this meeting will be filmed for live or subsequent broadcast via the City Council's website. At the start of the meeting, the Chair will confirm if all or part of the meeting is to be filmed.

Report author: Angela Brogden

Tel: 0113 3788661

Update on the development of the local Integrated Care System

Date: 26th April 2022

Report of: Head of Democratic Services

Report to: Scrutiny Board (Adults, Health and Active Lifestyles)

Will the decision be open for call in? ☐ Yes ☒ No

Does the report contain confidential or exempt information? ☐ Yes ☒ No

What is this report about?

Including how it contributes to the city's and council's ambitions

- During its previous meetings on 27th July 2021, 7th September 2021 and 16th November 2021, the Adults, Health and Active Lifestyles Scrutiny Board has been briefed on the implications of the new Health and Care Bill 2021-22 in context for health and social care in West Yorkshire and Leeds, particularly with regard to the development of the local Integrated Care System (ICS).

- The Bill required Clinical Commissioning Groups (CCGs) to propose the constitution of the ICB and before making a proposal, consult anyone they consider it appropriate to consult. In West Yorkshire, the CCGs agreed that the West Yorkshire Health and Care Partnership should co-ordinate the development of the constitution and involvement with stakeholders.

- On 11th January 2022, the draft constitution of the West Yorkshire ICB and supporting governance documents were presented to the Scrutiny Board (Adults, Health and Active Lifestyles) for its consideration and feedback. This formed part of wider stakeholder involvement from 8 November 2021 to 14 January 2022.

- The Scrutiny Board had agreed to maintain a watching brief in terms of the ongoing development of the local ICS. As such, the Leeds NHS Clinical Commissioning Group has provided a briefing note setting out the latest position for the Board's consideration.

Recommendations

The Scrutiny Board is asked to consider and discuss the content of this report and the appended documents.

Why is the proposal being put forward?

1. The Health and Care Bill 2021-22 was published and introduced in the House of Commons on 6 July 2021. Having previously discussed the implications of this new Bill in context for health and social care in West Yorkshire and Leeds, the Adults, Health and Active Lifestyles Scrutiny Board agreed to maintain a watching brief regarding the development of the local Integrated Care System (ICS).

2. From July 2022, ICSs will be put onto a statutory footing and comprise an Integrated Care Partnership (ICP) and an Integrated Care Board (ICB).

3. The West Yorkshire Health and Care Partnership published the draft constitution of the West Yorkshire Integrated Care Board for consultation on 8th November 2021 and the Scrutiny Board (Adults, Health and Active Lifestyles) utilised its meeting on 11th January 2022 to consider and provide feedback on the draft constitution as part of the broader consultation process.

4. The Chair of the Scrutiny Board then wrote to the Chief Executive (Designate) of the West Yorkshire Health and Care Partnership highlighting the main points raised by the Scrutiny Board in relation to the constitution document (see Appendix A).

5. The Scrutiny Board had agreed to maintain a watching brief in terms of the ongoing development of the local ICS and particularly requested sight of the report summarising the consultation findings and indicative changes made to the WY ICB constitution in light of the broader consultation feedback. The Leeds NHS Clinical Commissioning Group has therefore provided a briefing note setting out the latest position for the Board's consideration (see Appendix B).

What impact will this proposal have?

Wards affected: All		
Have ward members been consulted?	☐ Yes	☐No

6. With the publication of the Bill, the Scrutiny Board previously acknowledged that further guidance was still expected from the government, particularly surrounding future governance arrangements linked to the ICS. The Scrutiny Board therefore agreed to maintain a watching brief in terms of the ongoing development of the local ICS.

What consultation and engagement has taken place?

7. The government ran a formal consultation process on its proposals before publishing the Health and Care Bill 2021-22.

8. Senior representatives from across the local health and care system had contributed to the Scrutiny Board's previous meetings in July, September, November and January to discuss the ongoing development of the local ICS.

9. The West Yorkshire Health and Care Partnership published the draft constitution of the West Yorkshire Integrated Care Board on 8th November 2021 for consultation with stakeholders until 14 January 2022.

10. During today's meeting, representatives from Leeds NHS Clinical Commissioning Group will be leading on presenting the updated position on the development of the local ICS to the Scrutiny Board.

What are the resource implications?

11. Information relating to associated resource implications is set out within the appended briefing note from the Leeds NHS Clinical Commissioning Group.

What are the legal implications?

12. The proposals set out in the Health and Care Bill are intended to pass into law on 1st July 2022.

What are the key risks and how are they being managed?

13. Information relating to associated resource implications is set out within the appended briefing note from the Leeds NHS Clinical Commissioning Group.

Does this proposal support the council's three Key Pillars?

☐ Inclusive Growth ☒ Health and Wellbeing ☐ Climate Emergency

14. The Leeds Health and Well-being strategy sets out the ambition that Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. The aims of integrated care support many of the strategy's priorities including "the best care, in the right place, at the right time".

Appendices

15. Appendix A – A copy of the letter sent by the Chair of the Adults, Health and Active Lifestyles Scrutiny Board to the Chief Executive (Designate) of the West Yorkshire Health and Care Partnership highlighting the main points raised by the Scrutiny Board during its meeting on 11th January 2022 in relation to the draft West Yorkshire ICB Constitution document.

16. Appendix B – Briefing note from Leeds NHS Clinical Commissioning Group on the latest position regarding the draft ICB Constitution and Leeds Place Based Governance arrangements.

Background papers

17. None.

Chair, Scrutiny Board (Adults, Health and Active Lifestyles)
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E-Mail address:
Civic Hall tel: 0113 3788816
Our ref: AMK/AB

FAO: Rob Webster CBE
Chief Executive - Designate,
West Yorkshire Health and Care Partnership

Sent via e-mail only

21st January 2022

Dear Rob,

Re: Consultation on the draft West Yorkshire ICB Constitution

I am writing on behalf of the Adults, Health and Active Lifestyles Scrutiny Board to confirm that the Board had formally met on 11th January 2022 to consider the draft West Yorkshire ICB Constitution document that had been published by the West Yorkshire Health and Care Partnership as part of the wider consultation process. This was a public meeting and so the agenda pack and webcast recording of the discussion is available on the Council's website (https://democracy.leeds.gov.uk/ieListDocuments.aspx?CId=1090&MId=11623).

We welcomed the attendance of Tim Ryley, Chief Executive of Leeds Clinical Commissioning Group, who was also acting in his capacity as Chair of the ICS Governance Working Group in terms of presenting and addressing any questions on the draft constitution document, while also gathering the Board's feedback as part of the consultation process.

However, I felt it would be helpful to also write to you directly to highlight the main points raised by the Scrutiny Board in relation to the constitution document.

- *Endorsing the ten principles for working with people and communities.*

We very much support and welcome the ten principles set out by NHS England for working with people and communities, which are reflected within the constitution document. In particular, we recognise the vital importance of putting the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.

- *Acknowledging the importance of delivering on the integrated care strategy set by the Integrated Care Partnership*.

We are very pleased to note that the constitution document makes it explicit that the ICB will work to deliver the integrated care strategy that is to be set by the Integrated Care Partnership, particularly as one of the agreed guiding principles of the Partnership is to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing.

Continued……

- *Welcoming the inclusion of Healthwatch and Public Health in the composition of the ICB Board.*

In the absence of any requirement set within the Health and Care Bill to include the perspective of Healthwatch and Public Health in the composition of an ICB, we commend West Yorkshire's approach in leading the way and recognising the value that these appointments will bring to the membership of our local ICB.

- *Ensuring transparent decision-making and having robust arrangements to manage any actual and potential conflicts of interest.*

Having sought further clarification of the appointment process for providers, we were advised that no private healthcare providers are envisaged to be part of the West Yorkshire ICB membership, except for General Practice representatives. Linked to this, we still acknowledge the importance of ensuring 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 affect the integrity of the ICB's decision-making processes.

As a high-level document, we note that the primary purpose of the constitution is to set out the overarching principles for ensuring accountability and transparency of the ICB decision-making processes, with further detail to be provided in an accompanying Governance Handbook and separate policy documents, including policies for managing conflicts and standards of business conduct. While these remain under development, the Scrutiny Board would very much welcome sight of these once available.

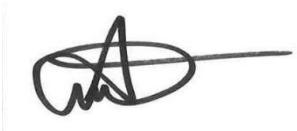
- *The ongoing development of place-based arrangements*.

Having already acknowledged the importance of putting the voices of people and communities at the centre of decision-making and governance at every level of the ICS, we recognise that place-based working will remain critical in this respect and welcome that the constitution does create the framework for the ICB to delegate much decision-making authority and resources to the five place-based partnerships in West Yorkshire.

Moving forward, once the broad constitutional principles are in place, we will therefore continue to monitor the ongoing development of the Leeds Place Based Partnership ICB Committee.

I hope that our feedback is helpful. I understand that a summary report will be produced to indicate what changes have been made to the ICB constitution in light of the broader consultation feedback and would therefore welcome a copy of this report to share with the Scrutiny Board.

Yours sincerely,



Councillor Abigail Marshall-Katung
Chair, Scrutiny Board (Adults, Health and Active Lifestyles)

Cc. Tim Ryley, Chief Executive of Leeds Clinical Commissioning Group

NHS
Leeds
Clinical Commissioning Group

Update to Scrutiny Board (Adults, Health and Active Lifestyles) – Draft ICB Constitution and Leeds Place Based Governance arrangements

Executive Summary

From July 2022, subject to legislation, Integrated Care Boards (ICBs) will take on the commissioning responsibilities of Clinical Commissioning Groups and lead the integration of health and care services across their area. This update provides detail on the development of the draft West Yorkshire Integrated Care Board (ICB) Constitution and supporting governance arrangements.

The delay in implementing the Health and Social Care Act until 1st July 2022 presents challenges for the system, but also presents an opportunity to develop our governance arrangements through a longer period of shadow operation. The ICS Governance Working Group has been co-ordinating the development of our governance arrangements, ensuring alignment between place and WY.

On 11 January 2022, the draft constitution of the West Yorkshire ICB and supporting governance documents were presented to the Scrutiny Board (Adults, Health and Active Lifestyles). This formed part of wider stakeholder involvement from 8 November 2021 to 14 January 2022.

Feedback from involvement highlighted the need for the governance handbook to cover the wider partnership collaborative arrangements that will inform ICB decision-making, in particular the role of Health and Wellbeing Boards and the integrated care partnership (the existing WY Partnership Board) in setting strategy and the role of provider collaboratives in partnership working at place and system level. In response to this feedback, case studies are being developed which will include decision making across both places and ICS footprints.

The draft ICB Constitution

The draft ICB constitution was published on 8 November 2021 and presented to the WY&H Partnership Board in December. The principles of subsidiarity mean that the ICB will primarily discharge its duties through delegation to ICB place committees, alongside work that is delivered at WY level. Most decisions will be made at place level, in support of local Health and Wellbeing Board priorities.

Involvement on the constitution produced responses from partners, external stakeholders and members of the public. In addition, proposals were presented to place and WY level forums including Health and Wellbeing Boards, health overview and scrutiny committees, partner boards and governing bodies, patient and public reference groups and partnership collaborative forums.

The feedback was constructive and covered a wide range of areas. The issues receiving most responses were:

- the size and composition of the ICB Board
- the arrangements for delegating the ICBs functions to our places
- public and patient involvement in our ICS.

Some of the main changes that have been made to the constitution include:

- clarifying objectives to promote a comprehensive health service, reduce health inequalities and improve wellbeing
- strengthening independent challenge by an additional independent non-executive member of the board with a specific focus on citizen involvement and sustainability
- strengthening the focus on people and workforce issues by adding a Director of People to the Board and establishing an ICB People Committee
- confirming that all board members are full members of a unitary board, responsible for stewardship of NHS funds and bound by individual and collective accountability for decisions
- enabling a broader range of representation on the board from providers of community health services and the voluntary, community and social enterprise sector
- building into the arrangements an annual review of Board effectiveness and our wider governance arrangements.

Other important comments were received which will be reflected in the governance handbook. These include:

- setting out the key role of Health and Wellbeing Boards in setting strategy
- illustrating the role of provider collaboratives in decision making and partnership working at place and system level
- outlining the potential mechanisms for decision taking across place and ICS footprints.
- setting out clearly in the scheme of reservation and delegation the principles for determining the decisions that will be made at West Yorkshire level
- reviewing the arrangements for involving citizens. This will include developing a wider citizen panel that will support the work of the ICB and existing involvement methods in place and at a West Yorkshire level and will be coordinated by Healthwatch.

During its meeting on 1st March 2022, the West Yorkshire Health and Care Partnership Board received a report on the West Yorkshire Integrated Care Board constitution and governance. This report included a summary of the consultation feedback and the changes made in response to the consultation (this is provided at Annex 1), along with an amended version of the draft constitution (this is provided at Annex 2).

In response to the consultation feedback, the report to the West Yorkshire Health and Care Partnership Board also included the following:

- Draft governance handbook contents (this is provided at Annex 3);
- Draft scheme of reservation and delegation outlining key functions and decisions (this is provided at Annex 4);
- Functions and decisions map - a 'plan on a page' of how decisions will be made (this is provided at Annex 5);
- Governance structure diagram (this is provided at Annex 6); and
- ICS governance standards (this is provided at Annex 7).

The ICB Board

The ICB board will be one part of a complex, mature and inclusive decision-making framework, ensuring inclusivity, independent challenge and effectiveness across our system. In response to feedback, some changes are proposed to the membership, which now includes:

- An additional independent non-executive member.
- The member bringing the perspective of providers of community services will no longer be restricted to NHS trusts.
- The addition of Board roles for the Director of People and Director of Strategy and Partnerships.

The revised proposed membership of the Board is:

Proposed WY ICB Board	**Minimum national requirement**
Independent perspective • Chair • 4 Independent Non-Executive members	• Chair • 2 Non-Executive directors
Healthwatch perspective • Healthwatch	• No requirement
Place perspective • 5 Place members • Local authority	• No requirement • 1 local authority.
Provider perspectives • Acute provider • Mental health, learning disability and autism provider • Community provider • Primary medical services • Voluntary, community and social enterprise sector	One member drawn from • NHS trusts and foundation trusts • primary medical services (general practice) providers
Public health perspective • Director of Public Health	• No requirement

System executive, clinical and professional • Chief Executive • Director of Finance • Director of Nursing • Medical Director • Director of People • Director of Strategy and Partnerships	• Chief Executive • Director of Finance • Director of Nursing • Medical Director • No requirement • No requirement
Total Board: 24	10

Committees of the ICB

Each of the five places across West Yorkshire is establishing an ICB committee to take decisions about ICB functions and resources and is currently recruiting to independent roles on these committees. In addition to place committees, West Yorkshire-level committees are proposed to support the ICB Board in carrying out its functions and ensure that decision-making is transparent, with clear accountability. Except for the Audit and Remuneration Committees, all meetings will be held in public. The proposed committee structure is:

Committee	Remit
Place x5	Annual plan to deliver place health and wellbeing strategy, allocate resources, arrange the provision of health services.
Finance, Performance and Investment	System planning, performance improvement and review, finance and investment.
System Quality	System quality improvement, risk, assurance.
Transformation	Clinical thresholds, service specifications, pathways.
People	System people plan and priorities, workforce investment, workforce models.
Audit	Governance, risk management and internal control processes.
Remuneration and Nomination	Remuneration of directors and other very senior managers, ICB pay policy, succession planning

The Integrated Care Partnership and wider decision-making

The formal ICB committee decision-taking structure will be only part of the inclusive partnership decision-making infrastructure. The current WY Partnership Board will become the WY Integrated Care Partnership and set the system strategy. The Partnership Board will be a joint committee of the ICB and local authorities and will not be able to be formally established until the ICB is established in July. Work is underway to liaise with local authority governance colleagues over the arrangements

for formally establishing the ICP. Until the ICP is formally established, it is proposed that the Partnership Board continues to meet in its current form.

Existing collaborative forums, such as the System Leadership Executive and Clinical Forum and our provider collaboratives will continue to play a key role in building consensus, socialising development proposals and network development.

Leeds Place Based Governance Arrangements – Leeds Health & Care Partnership

The Leeds Committee of the ICB continues to be developed, the membership has been agreed and the Committee is meeting in Shadow form throughout April to June. Recruitment has concluded in terms of the Independent Members and two Independent Members have been appointed subject to pre-employment checks. Interviews for the Independent Chair of the Committee took place but were unsuccessful and are out to recruit again (closing date 12 April 2022).
Work is continuing on developing the three Sub-Committees, in particular in relation to the membership and terms of reference and these will start operating in Shadow form throughout April to June.

Further work has started but has not yet been completed on how the Clinical Leadership strategy links into the emerging landscape and similarly work on ensuring the city Race Equality Networks are influencing the agenda.
More broadly the Leeds Health & Care Partnership continues to be developed with considerable work and engaged conversations around the Operating Model, the transition to new ways of working without the CCG role, and the further strengthening of governance and population health management in the city through the morphing of existing boards and groups to become Population Health or Care Delivery Boards.

Recommendations

The Scrutiny Board is recommended to:

a) Comment on the key messages from stakeholder involvement on the draft constitution; and

b) note that the constitution remains in draft and is subject to legislation and regulations and that work is ongoing to further develop the governance handbook.

Annex 1

Draft West Yorkshire Integrated Care Board constitution

Report on responses to involvement

Introduction

1. From 1 July 2022, subject to legislation, integrated care boards (ICBs) will take on the commissioning responsibilities of clinical commissioning groups (CCGs) and lead the integration of health and care services across their area. This report presents the findings of stakeholder involvement on the draft constitution of the West Yorkshire Integrated Care Board (ICB).

2. The Health and Social Care Bill requires the relevant CCGs to propose the constitution of the first ICB to be established for that area. Before making a proposal, the relevant CCGs were required to involve anyone they considered it appropriate to engage. Although formal consultation on the draft constitution was not required, the CCGs in Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield agreed to undertake a joint stakeholder involvement exercise at both Partnership and local level. To enable all stakeholders and interested parties to contribute, a comprehensive constitution involvement and communication toolkit was produced.

Approach to involvement

3. On 8 November 2021, we published our draft constitution on our website, alongside supporting communications including background information, easy read, audio and British Sign Language versions. The involvement period closed on 14 January 2022. Comments were invited on the content of the draft constitution and several supporting documents. We asked for feedback on:

   - the composition of the Board of the ICB.
   - the appointments process for members of the Board of the ICB.
   - the delegation of functions to place-based committees of the ICB
   - the way the ICB proposes to deal with conflicts of interest.
   - the ICB's principles for ensuring accountability and transparency.
   - how the ICB will comply with the requirements of the NHS Provider Selection Regime (subject to regulations).
   - the way the ICB intends to involve the public, patients, carers and stakeholders.

4. In addition to publishing the draft constitution on the Partnership website, we also presented the proposals to a range of forums including:

   - patient and public reference groups;
   - Health and Wellbeing Boards;
   - West Yorkshire and place Health Overview and Scrutiny Committees;
   - partner organisation boards and governing bodies; and
   - partnership forums including the Partnership Board, System Leadership Executive, Chairs and Leaders Reference Group, Clinical Forum and Communication and Engagement Network.

Responses to the engagement

5. Involvement on the constitution produced responses from partners, external stakeholders and members of the public (see enclosed list). The feedback has been very helpful and constructive and has covered a wide range of areas. The issues receiving most responses were:

   - the size and composition of the ICB Board;
   - the arrangements for delegating the ICBs functions to our places; and
   - public and patient involvement in our ICS.

6. A summary of the key issues raised during the involvement period is attached at Annex 2, together with our response and how we propose to amend the draft constitution. The main changes that we have made in response to comments include:

   - clarifying the objectives of the ICB in relation to promoting a comprehensive health service for all its residents, reducing health inequalities and improving wellbeing;
   - strengthening independent challenge and scrutiny by including an additional independent non-executive member of the board with a specific focus on citizen involvement and sustainability;
   - strengthening our focus on people and workforce issues by adding an ICB Director of People to the Board and establishing an ICB People Committee;
   - confirming that all members of the board are full members of a unitary board, responsible for stewardship of NHS funds and bound by individual and collective accountability for decisions;
   - enabling a broader range of representation on the board from providers of community health services and the voluntary, community and social enterprise sector; and
   - building into our arrangements an annual review of Board effectiveness.

7. Several other important comments were received, which we will reflect in the governance handbook. The handbook will underpin the constitution and our wider partnership arrangements. In response to comments, we will:

   - set out the key role of Health and Wellbeing Boards in setting strategy;
   - illustrate via case studies the role of provider collaboratives in decision making and partnership working at place and system level;
   - develop case studies to illustrate the potential mechanisms for decision taking across place and ICS footprints;
   - set out clearly in the scheme of reservation and delegation the principles for determining the decisions that will be made at West Yorkshire rather than place level; and
   - review our arrangements for involving citizens - this will include developing a wider citizen panel as recommended in the independent public involvement review (July 2021) - this will support the work of the ICB and existing involvement methods in place and at a West Yorkshire level and will be coordinated by Healthwatch.

Summary

8. Stakeholder involvement on the draft ICB constitution has proved very valuable in refining key aspects of the constitution and our supporting governance and citizen involvement arrangements.

Responses were received from:

- 10 members of the public
- Airedale NHS Foundation Trust
- BMA Yorkshire Regional Council
- Calderdale and Kirklees 999 Call for the NHS
- Community Pharmacy West Yorkshire
- Kirklees Council
- Kirklees Health Overview and Scrutiny Committee
- Leeds Adults, Health and Active Lifestyles Scrutiny Board
- Leeds CCG
- Leeds CCG PPG Network Group
- Leeds Community Healthcare NHS Trust
- Leeds Keep Our NHS Public
- Leeds Local Medical Committee
- Leeds and York Partnership NHS Foundation Trust
- Locala Community Partnerships
- Mid Yorkshire Hospitals NHS Trust
- Nova Wakefield District Limited
- South West Yorkshire Partnership NHS Foundation Trust
- Wakefield Patient and Community Panel,
- West Yorkshire Joint Health Overview and Scrutiny Committee
- Yorkshire Ambulance Service NHS Trust

Involvement on West Yorkshire Integrated Care Board draft constitution – summary of feedback and proposed responses 21.02.22

Feedback on draft constitution	Response/proposed amendment to constitution/governance arrangements
Section 1 – Introduction	
Objectives and priorities	
• Promotion of comprehensive health service should be explicit in the objectives. Important to specify the population covered by ICB – ensure no gaps in provision.	• Reflect comprehensive health service and resident population in updated draft. **(Clause 1.1.2)**
• The people and workforce agenda needs more emphasis.	• Importance of people/workforce agenda recognised by proposed establishment of ICB People Committee, Director of People on ICB Board, Independent Non-Executive Member with responsibility for workforce.
• Welcome focus on wider determinants of health, outcomes rather than activity. Focus more on wellbeing than 'health', because this better describes overall health. Support focus on prevention, partnership and health inequalities. Need to recognise poverty as a determinant of health.	• Additional references to priority outcomes and poverty as a determinant of health (**1.1.16).**
How we work together	
• Need to set out role of Health and Wellbeing Boards more clearly.	• Key role of Health and Wellbeing Boards in setting strategy highlighted **(1.1.4)** also set out in functions and decisions map. Place ICB Committees will agree a plan to deliver the Health and Wellbeing Strategy. This will also be covered in the governance handbook.
• Embed clinical and professional leadership throughout ICS structures	• ICB Board will be just one part of a complex and inclusive decision-making framework, which embeds clinical and professional leadership across our system and at board level. At the centre is

	the Clinical Forum, which will remain as the primary forum for clinical leadership, advice, and challenge of the work of the Partnership.
• Language important: 'Local Care Partnerships' rather than PCNs.	• Terminology changed **(1.1.14).**
• Recognise and support contribution of voluntary community and social enterprise sector (VCSE)	• VCSE is represented on ICP, ICB Board, Place Committees and in wider partnership structures.
• Greater emphasis needed on keeping people well in their own homes through collaborative working	• Additional text added **(1.1.18).**
• Recognise role of partners including community interest companies, hospices, and independent social care providers.	• Additional text added **(1.1.8)**
• Collaborative behaviours and relationships are as important as formal governance structures at both place and WY level. Wherever possible, we should streamline formal governance and avoid layers of bureaucracy and duplication.	• We recognise the importance of collaborative relationships. Formal decision-making mechanisms will continue to be underpinned by the work of collaborative forums and networks.
• How is the primacy of strategies determined i.e. each provider's strategy, that of the place partnerships and the and the ICB, and how do we agree these?	• Willingness to collaborate will remain key in ensuring that strategies are complementary across organisations, places, and West Yorkshire.
• Important that all ICB partners and stakeholders are treated equally and fairly because the outcomes for the communities that the ICB serves are more important than the organisational form of the bodies who deliver those improved outcomes.	• New text added **(1.1.21)**

Section 2 - The ICB Board – composition **Roles**	
• There needs to be greater clarity on how the Board will work and how it will make decisions, not just its composition. There needs to be clarity on the roles of those who sit round the table	• All Board members have a vote and share accountability for ICB decisions. The constitution states explicitly in para 2.4 that the partner board member role is to bring the perspective of sector/place, not to act as a representative or delegate of the sector or organisation.
• The Constitution should clarify how the IC Board Chair and Chief executive can be removed from office and on what grounds.	• The arrangements are set out in **3.20**.
• The Constitution should clarify if partner members are ordinary members or exec members, and what the difference is between ordinary and exec members. Are all Board members jointly accountable?	• New text added to confirm that partner members are full members of a unitary board, responsible for stewardship of NHS funds and are bound by individual and collective accountability for decisions.
Terms of office for partner members	
• Partner members – proposed three x three year terms may preclude CE from continuing as a member when still being accountable in a provider trust.	• The Board trust partner member role is to bring the perspective of the sector, not to act as a representative or delegate of the sector. Limiting the terms served will help to promote diversity and inclusivity.
• Could consider re-nomination by Provider trusts at regular intervals or rotational representation from trusts	• Rotational representation is not possible under expected statutory regulations.
Composition	
• Concern that board too big for effective decision-making.	• We have sought to balance inclusiveness and effectiveness. Annual review of board size and effectiveness built into constitution**. (3.23) (4.1.3)**

• Additional frontline clinical representation needed - primary care, secondary care, public health doctors	• The board includes Medical Director, Director of Nursing, primary care member and Director of Public health. Clinical subject matter experts will also be invited to attend as required. There is also a Non-Executive Independent Member for Quality and there will be a Quality Committee.
• The board should include the public, 1 councillor from each local authority, Trade Union representatives, 1 Social Care representative and 1 each from dentistry and NHS maternity services.	• We have sought to balance inclusiveness and effectiveness on our board and members will bring the perspective from citizens and a wide range of sectors. The board will be just one part of a complex and inclusive ICS decision-making framework which enables the involvement of very wide range of stakeholders.
• Important that there is independent public health specialist on ICB and the Partnership Board , to provide expertise on public health rather than to represent a specific organisation.	• The role of the Director of Public Health board member will be to bring the perspective of Directors of Public Health, not represent a specific organisation.
• Should not have private providers on Partnership board or ICB board.	• Private providers are not included on our ICB Board. There are no private providers on our existing Partnership Board, although we propose to broaden its membership to include a representative of independent providers of social care. All board members must declare any conflicts of interest.
• Patients/public/citizen voice. At least 2 patient representatives are needed on the ICB Board to ensure that patient voice is heard	• ICB Board has an independent Chair and four non-executive independent members – one of whom has a specific remit around citizen voice. In addition, there will also be a Healthwatch Board member. Meetings will be held in public, and the public will be encouraged to ask questions on agenda items. All questions and answers will be publicly available.
• Yorkshire Ambulance Service should be represented in view of importance of ambulance service to broad range of Partnership priorities.	• Yorkshire Ambulance Service NHS Trust (YAS) are embedded in our Partnership leadership structures and we will invite them to Board meetings for matters on which they have an interest. We will keep

	under review over time. YAS will also have a key role in Yorkshire and Humber inter-ICS governance arrangements.
• Insufficient social care representation on the Board	• The local authority member and place leads with local authority responsibilities will bring the perspective of social care.
• Representative of community services providers on the board should not be restricted to NHS trusts.	• Eligibility criteria will be amended so that the member bringing the perspective of providers of community services is no longer restricted to NHS trusts.
• Local authority elected members should be able to sit on ICB Board.	• Under national guidance, elected members were that not eligible to be members of the ICB Board. **(Note: the Bill has subsequently been amended. Elected members are no longer ineligible, although guidance sets out that it is expected that the member 'will normally be a senior local authority executive'.**
• There is a need to ensure that the Board is representative of the breadth of service provision, particularly mental health and learning disability	• The Board includes a partner provider member who will bring the perspective of mental health, learning disability and autism.
• Requiring provider partner members to be at CEO level within partner organisations this could, by default, introduce a gender and ethnicity bias.	• The Bill requires that trust partner members must be at executive director level.
• Provider collaboratives are not represented on the Board.	• Trust partner members of the Board will bring the perspective of their sector, including that of provider collaboratives.
• Community pharmacy should be represented on the Board and across the Partnership.	• Community pharmacy is represented on the Clinical Forum. We will invite them to Board meetings for matters on which they have an interest. We will keep under review over time.

• Places are not adequately represented on the Board.	• Each of our five places will have one member on the ICB Board. In addition, each of the sector representatives (for example NHS trusts and local authorities) will also bring insight from their local places too.
• The list of members states "Director of Nursing", however, this should be broader than just nursing and should be representative of other professional groups including Allied Health Professions.	• The director of nursing role is prescribed in the Bill.
• Suggest non-eligibility for independent members should include roles within CQC, Healthwatch, NHSE or DHSC.	• These organisations are covered by the requirement not to hold a role in health or care in the ICS area.
• Important not to exclude groups representing other protected characteristics from being in attendance at ICB Board. Inclusivity should be the golden thread through every level of governance of the ICS.	• We are reviewing our proposals for groups 'in attendance' at Board meetings.
Section 3 - Appointment process for the ICB Board	
• What processes will the ICS be using to appoint the statutory roles on its ICB – particularly its GP and medical director members?	• There was an been open, transparent and robust recruitment for all statutory executive board roles. National guidance is yet to be issued on the nomination and appointment process for the primary care member.
• Role of the ICB Chair in approving Board members.	• It is a national requirement that all Board appointments are approved by the ICB Chair.
• VCSE: eligibility criteria too restrictive and should not exclude a person from an infrastructure organisation. Sector should lead the process. Specifying a "senior leader" may exclude representatives from some groups – especially those affected by inequalities. Need	• Amend eligibility criteria to include VCSE infrastructure organisations **(3.15.2)**. Nomination process will be led by the sector. VCSE member must be able to bring the perspective of the whole VCSE sector and have experience in strategic decision making at a

backfill payments for the voluntary sector as this work is not funded.	senior level. Agree that VCSE representatives should not be deterred from taking on roles within the ICB at West Yorkshire or place level because of funding issues. We are working to develop appropriate arrangements.
• There needs to be greater clarity on the process, in particular what safeguards there are to make this as inclusive as possible.	• All nomination and appointment processes include a requirement to have regard to the Partnership's commitment to improving the diversity of its leadership and to ensuring a spread of representation across our places.
Section 4 - Arrangements for the Exercise of our Functions	
• Governance handbook is key document – must be made available for scrutiny and comment.	• The governance handbook is currently being developed and will be published on our website. It will include the scheme of reservation and delegation, committee structure, terms of reference, key governance policies and decision-making case studies.
• Subsidiarity and place-based decision making must be emphasised. Important to set out what decisions are made at ICS and at Place level. There needs to be recognition in the Scheme of Delegation that the ICB decision making is driven by bottom-up recommendations and what is happening at Place	• The draft constitution and functions and decisions map are based on principles of subsidiarity, with decisions being taken as close as possible to local communities. Place-based ICB committees will play a key role in this.
• There needs to be clarity on how we avoid duplication of effort between ICB and Place. For example, what is the distinctive role of the ICB and how will it add value to the decision-making process.	• Distinctive role of the ICB is defined by the 3 tests **(1.1.5)**. This will also be set out in the scheme of reservation and delegation and governance handbook.
• Need flexibility to address issues/make decisions across 2 or more places, not just system e.g. hospital reconfigurations.	• The constitution includes the flexibility for committees, including place committees to establish governance mechanisms to address specific needs **(4.6.1)**. We will illustrate potential options through case studies/examples in the governance handbook.

• Need to set out arrangements for decisions on services covering more than 1 ICS.	• We are developing case studies for inclusion in the governance handbook.
• Arrangements are complex and hard to understand. There needs to be greater clarity on how collaborative governance arrangements will operate, setting out how functions will not only be delegated, but how matters can be escalated up through the various ICB / Place governance structures.	• We will seek to clarify the arrangements in the functions and decisions map, governance structure diagram and the Scheme of reservation and delegation.
• The Governance Handbook should specify that there must be no delegation of the Integrated Care Board's powers and functions.	• All proposed delegation is to committees of the ICB or ICB board member and employees.
• Across the Constitution there needs to be greater clarity on the duty to collaborate alongside the over-riding duty of governance at an organisational level and how this fits with the individual governance arrangements.	• Section 1 of the constitution sets out the role of trusts as partners and at **1.1.12** and **1.1.13** the relationship with the ICB constitution
• In the governance structure diagram there is no reference to NHS Trusts or FT Boards as being statutory organisations involved in the decision-making process.	• The diagram is intended to focus on ICB decisions and functions rather than those of individual statutory organisations. We will amend the diagram to include governance arrangements in trusts and other statutory organisations.
• The role of provider collaboratives is not given sufficient coverage in the constitution.	• In line with our principles of subsidiarity, the model of delegation set out in the constitution and scheme of reservation and delegation is to place. Provider collaboratives will continue to play a key role within this model at both place and system level. We will develop case studies to illustrate the role of provider collaboratives. These case studies will be included in our governance handbook.
• Add reference to remind the ICB committees that they must have full regard to the values in 1.1.20.	• Text added at (**4.6.4)**.

Section 6 - Conflict of Interests and Standards of Business Conduct	
• Conflicts must be managed carefully, particularly in relation to the role of provider members of the Board and committees.	• ICB will have a conflicts of interest policy which will be applied to all ICB decision taking. This will cover the role of provider members. Further guidance on managing conflicts of interest is expected from NHS England.
Section 7 - Accountability and Transparency	
• What are the arrangements for having lay members on ICB/ICP decision making bodies.	• The Partnership Board, ICB board and its committees will all include at least one member who is independent of health or care organisations in the relevant footprint.
• Need for greater clarity on compliance with the provider selection regime including the relative importance of all material selection criteria.	• Additional wording added **(7.3.3).** Further detail will be in the provider selection regime regulations, once published.
• Detail is needed on compliance with Freedom of Information regulations and Data Protection regulations	• Para 1.4.5 sets out the ICB's statutory duties on data protection. Section 7.2 outlines the ICB's duties on Freedom of Information. The detail will be covered in separate policies.
• Specify that compliance with local authority health overview and scrutiny requirements includes joint health overview and scrutiny requirements.	• Additional wording added at **7.3.4.**
Section 8 – Terms and conditions of employees	
• Is there any commitment to follow Agenda for Change conditions for existing staff transferred from CCGs and new ICB staff?	• We will follow the national NHS employment commitment: "NHS people within the wider health and care system (below board level) affected directly by these legislative changes, including CCGs, NHS England and NHS Improvement and NHS providers, will receive an

	employment commitment to continuity of terms and conditions…this commitment is designed to provide stability and remove uncertainty during this transition to follow Agenda for Change conditions for existing staff transferred from CCGs and new ICB staff"
• Duties of the Remuneration and Nomination Committee could include the alignment of remuneration to those within the West Yorkshire ISC system, for example Agenda for Change.	• Additional wording added at **(8.6).**
Section 9 - Public involvement	
• How does ICS plan to involve patients in the work of its ICB and ICP? Is any patient assurance planned at WYH level?	• We are committed to involving local people in our work and in decision making at West Yorkshire and place level. Our ambition is to go much beyond solely meeting the statutory duty. This means we will be looking at a continuous cycle of active involvement in our decision-making committees as well as our system level programmes. Involving people and communities is one of our guiding principles. Healthwatch will be supporting this role, alongside local places and West Yorkshire programmes to ensure people remain at the centre of all we do.
• There should be mechanisms in place for people across joined up care to feedback and understand how this has been used to shape services.	• Public and patient involvement is not limited to Board membership. We have independent co-opted public members on the Partnership Board, lay members on programme boards, a citizen panel for planned care, cancer community panel and youth collective voice group. We have strong partnerships with carers groups and organisations that have good relationships with seldom heard groups. • Each of our places will have independent representation on their decision-making committees. At a West Yorkshire level there will be

	independent members on our ICB Board and Integrated Care Partnership. Healthwatch will also be involved in these forums. Formal decision-making will be informed by the wider approach to public involvement set out in our communications and involvement plan and involvement framework.
• Will the disabled community have representation in the ICB? Will there be representation and understanding of the needs of staff who have a disability or long term condition in the ICB – not all disabilities are visible.	• The ICB will adopt the ten principles outlined by NHS England for working with people and communities. Amongst these principles is to put the voices of people and communities at the centre of decision-making and governance and to build relationships with excluded groups – especially those affected by inequalities, such as people with disabilities. The work is supported by our involvement framework, and the communication and involvement plan, and involvement principles which are continually being updated, and coproduced.
• Arrangements for public participation in meetings of the IC Board (and any other bodies that it delegates its functions to) should be no less than current arrangements for public participation in the non-statutory ICS Board meetings and CCG meetings.	• ICB decision-taking meetings will be held in public, and the public and patients will be encouraged to ask questions on the agenda items. All questions and answers will be publicly available. The Board will have a representative from Healthwatch
• There need to be easy read minutes of ICB meetings as well as recordings of meetings which are publicly accessible. In addition, consideration should be given to BSL signed meetings and the availability of translation services. There needs to be greater clarity as to how the ICB will receive information about patient experience.	• Arrangements for the ICB Board are under review.
• The constitution should specify that the ICB Annual (rolling) 5 Year Plan should be an accurate, current, readily accessible and understandable source of public information. There should be meaningful public consultation on the plan.	• The annual plan will provide accessible and understandable information. Wording at **9.2** added to confirm compliance with national and local involvement principles.

NHS West Yorkshire Integrated Care Board Constitution: Draft V 0.4

Notes

This draft is based on the national model constitution. Text in black indicates a legal or policy requirement and should be retained unless agreed otherwise with NHS England. Text in track changes indicates a change from the version V.02 issued for stakeholder involvement on 8 November 2021.

Text highlighted in yellow indicates a change in the national model constitution since draft V0.2 was issued.

The constitution is a high-level document, subject to legislation, regulations, and guidance from NHS England. The detail of our arrangements is still under development and will be included in a separate Governance Handbook, which we will publish.

Version	Date	Changes
0.1	14.09.21	Outline draft circulated to ICS Governance Working Group
0.2	08.11.21	Comments and additional text from ICS Governance Working Group and ICS Senior Leadership forums, legal review.
0.3	21.12.21	Amendments to reflect: • revised model constitution issued 01.12.21 • review by NHS England
0.4	21.02.22	Amendments to reflect • responses to stakeholder involvement. • revised model constitution issued 11.02.22.

[Insert ICB logo]

NHS West Yorkshire Integrated Care Board

Part of the West Yorkshire Health and Care Partnership

CONSTITUTION

CONTENTS

1. Introduction

1.1 Background/ Foreword

1.1.1 NHS West Yorkshire Integrated Care Board is part of the West Yorkshire Integrated Care System (ICS), known as the West Yorkshire Health and Care Partnership. This constitution builds on the Memorandum of Understanding (MoU) that the Partnership agreed in 2018. That MoU set out our commitment to work together in partnership to realise our shared ambitions to reduce health inequalities, improve the health of the 2.4 million people who live in our area and improve the quality of their health and care services.

1.1.2 The Integrated Care Board (ICB) will work to promote the delivery of a comprehensive health service for the residents of West Yorkshire. NHS England has set out the following as the core purposes of ICSs

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

1.1.3 The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

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

1.1.4 The ICB will deliver the strategy set by our Integrated Care Partnership (ICP), which will be built from the health and wellbeing strategies agreed in each of our places. It will support the five place-based partnerships in West Yorkshire (Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield) as part of a well-established way of working to meet the diverse needs of our citizens and communities. These place-based partnerships, overseen by Health and Wellbeing Boards, and including councils, health and care providers, the voluntary community and social enterprise sector and Healthwatch, are key to achieving the ambitious improvements we want to see. In 2019 we set out our ambitions in our five year plan.

1.1.5 This constitution creates the framework for the ICB to delegate much decision-making authority and resources to our places. We recognise that there are also significant benefits in working together across a wider footprint

and that local plans need to be complemented with a common vision and shared plan for West Yorkshire as a whole. We apply three tests to determine when to work at this level:

- to achieve a critical mass beyond local population level to achieve the best outcomes;
- to share best practice and reduce variation; and
- to achieve better outcomes for people overall by tackling 'wicked issues' (i.e., complex, intractable problems).

1.1.6 The West Yorkshire Health and Care Partnership ('the Partnership') includes eleven NHS providers[1], who come together in provider collaboratives to achieve better outcomes for people and ensure sustainable services in the future. These collaboratives are the West Yorkshire Association of Acute Trusts and the West Yorkshire Mental Health, Learning Disability and Autism Alliance. These collaboratives are formal entities who may be delegated formal responsibilities from the ICB, but also play a recognised formal and informal system leadership role to help deliver operational support, deliver 'at scale' services and facilitate continuous development between partners.

1.1.7 The Partnership includes seven local government partners. The five Metropolitan Councils in West Yorkshire and North Yorkshire County Council lead on public health, adult social care and children's services, as well as statutory Health Overview and Scrutiny and the local Health and Wellbeing Boards. The Metropolitan Councils and Craven District Council lead on housing, licensing, planning, and environmental health which all influence the wider determinants of health. Together, they work with the NHS as commissioning and service delivery partners, as well as exercising formal powers to scrutinise NHS policy decisions.

1.1.8 The voluntary, community and social enterprise sector (VCSE), community interest companies, hospices, and independent social care providers also play a valuable role in the Partnership, working across all our places and programmes of work.

,

1.1.9 Healthwatch ensure that citizen voice is at the centre of the Partnership. We are committed to meaningful conversations with people and value highly the feedback that people share with us. Effective public involvement, particularly with those with lived experience and who are seldom heard, ensures that we make the right decisions together about our health and care services. Our approach to public involvement is set out in section 9.

[1] Number to be confirmed in line with secondary legislation

1.1.10 Our ultimate goal is to put people at the heart of everything we do so that together, we meet the diverse needs of all communities. People from Black, Asian and minority ethnic communities continue to face health inequalities, discrimination in the workplace and are more likely to develop and die as a result of serious diseases. Effective equality, diversity and inclusion (EDI) leads to improved health delivery and greater staff and patient experiences of the NHS. We want to ensure that our workforce is diverse and that people working and learning in ICBs can develop and thrive in a compassionate and inclusive environment and an organisational culture that promotes inclusion and embraces diversity. This will support and strengthen our response to tackling health inequalities through a whole systems approach.

1.1.11 This constitution sets out the role of the ICB in our partnership arrangements. It does not seek to introduce a hierarchical model; rather it supports a mutual accountability framework, based on principles of subsidiarity, to ensure we have collective ownership of delivery.

1.1.12 This constitution is based on the ethos that the ICB and our partnership is a servant of the people of West Yorkshire and of its member organisations. The ICB is a statutory body charged with specific legal duties and functions and there is no legal connection between the ICB constitution and the separate constitutions of other organisations in the ICS. The constitution does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Councils. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.

1.1.13 The constitution is underpinned by the duty for NHS bodies and local authorities to co-operate and supports the triple aim that requires NHS bodies to consider the effects of their decisions on the health and wellbeing of the people of England, the quality of services and the sustainable and efficient use of resources.

1.1.14 Our approach to collaboration begins in each of the neighbourhoods which make up West Yorkshire, in which GP practices work together, with community and social care services in local care partnerships ~~Primary Care Networks,~~ to offer integrated health and care services for populations of 30-50,000 people. These integrated neighbourhood services focus on preventing ill health, supporting people to stay well, and providing them with high quality care and treatment when they need it.

1.1.15 Neighbourhood services sit within each of our five places. These places are the primary units for partnerships between NHS services, local authorities, charities and community groups, which work together to agree how to

improve people's health and improve the quality of their health and care services.

1.1.16 The focus for these partnerships is moving increasing away from simply treating ill health to preventing it, to reducing health inequalities, and tackling the wider determinants of health, such as poverty, housing, employment, social inclusion and the physical environment.

1.1.17 The arrangements described in this constitution describe how we organise ourselves together to provide the best health and care, ensuring that decisions are always taken in the interest of the patients and populations we serve.

1.1.18 We have worked together as the Partnership to develop a shared vision for health and care services across West Yorkshire:

- Places will be healthy - you will have the best start in life, so you can live and age well.
- If you have long term health conditions you will be supported to self-care at home through primary care ~~,GPs and~~ social care and community services working together. This will include peer support and via technology, such as telemedicine.
- If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
- If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
- Local hospitals will be supported by centres of excellence for services such as cancer and stroke
- All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example, community and hospital care working together.
- Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

1.1.19 We have agreed a set of guiding principles that shape everything we do through our Partnership:

- We will be ambitious for the people we serve and the staff we employ
- The Partnership belongs to its citizens and to commissioners and providers, councils and NHS. We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing.

- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and a potential source of conflict
- We will undertake shared analysis of problems and issues as the basis of taking action
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible.

1.1.20 We commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire ;
- We support each other and work collaboratively;
- We act with honesty and integrity, and trust each other to do the same;
- We challenge constructively when we need to;
- We assume good intentions;
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery; and
- We will display the highest standards of inclusive behaviour and will be expected to adhere to expected competencies.
- We will treat all ICB partners and stakeholders equally and fairly, because the outcomes for our communities are more important than organisational form.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS West Yorkshire ICB ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is (insert appropriate description which must match that on the establishment order].

1.4 Statutory Framework

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

1.4.2 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.

1.4.3 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).

1.4.4 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 at [Add web address]

1.4.5 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 2009 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); and
f) Information law, (for instance, data protection laws, such as the UK~~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

1.4.6 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.

1.4.7 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).

1.4.8 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).

1.5 Status of this Constitution

1.5.1 The ICB was established on [date] by [*name and reference of establishment order*], which made provision for its constitution by reference to this document.

1.5.2 This constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.

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

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 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 and that application is approved; and

b) where NHS England varies the constitution of its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the constitution is as follows:

a) The Chair and/or Chief Executive may periodically propose amendments to the constitution, which shall be submitted to the Board for approval. If the changes are material, there will be an engagement process with partners in the ICB. Material changes will include changes to the membership of the Board or to decision-making procedures. Proposed changes will be submitted to NHS England for approval.

b) Proposed amendments to this constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

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

1.7.2 The following are appended to the constitution and form part of it for the purpose of clause 1.6 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 processes to appoint the ICB committees.

1.7.3 The following do not form part of the constitution but are required to be published.

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

b) Functions and Decision map- 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[2]– which includes:

- Terms of reference for all committees and sub-committees of the Board that exercise ICB functions.
- Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or

[2] The Governance Handbook will be published separately.

to a joint committee of the ICB and one of~~r~~ 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.
- [Add other key contents].

e) Key policy documents[3] - including:

- Standards of Business Conduct Policy
- Conflicts of interest policy and procedures
- Policy for public involvement and engagement

[3] Key policy documents are currently under development.

2. Composition of The Board of the ICB

2.1 This part of the constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in Section 3.

2.2 Further information about the individuals who fulfil these roles can be found on our website [add link].

2.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this constitution as "the Board" and members of the ICB are referred to as "Board Members") consists of:

a) a Chair
b) a Chief Executive
c) at least three Ordinary members.

2.4 The membership of the ICB (the Board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.5 NHS England Policy requires the ICB to appoint the following additional Ordinary Members:

a) three executive members, namely
- Director of Finance
- Medical Director
- Director of Nursing

b) At least two independent non-executive members

2.6 The Ordinary Members 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 Section 3 below**:**

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description
- the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description
- the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.

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.

Board Membership

2.7 The ICB has four ~~five~~ Partner Members.

a) 1 partner member - NHS trusts and foundation trusts providing acute services
b) 1 partner member - NHS trusts and foundation trusts providing mental health, learning disability and autism services.
c) 1 partner member - primary medical services.
d) 1 partner member - local authority

2.8 The ICB has also appointed the following further Ordinary Members to the Board

a) A Bradford, District and Craven place member.
b) A Calderdale place member.
c) A Kirklees place member.
d) A Leeds place member.
e) A Wakefield place member.
f) A provider of community services member
g) A Director of Public Health member.
h) A Healthwatch member.
i) A Voluntary, Community and Social Enterprise sector member.
j) A Director of People member
k) A Director of Strategy and Partnerships member

2.8 The board is therefore composed of the following members:

a) Chair
b) Chief Executive
c) 2 Partner members NHS and Foundation Trusts
d) 1 Partner members Primary medical services
e) 1 Partner member Local Authorities
f) 4 Independent non-executive members
g) Director of Finance
h) Medical Director
i) Director of Nursing
j) 1 member community services
k) 1 member Director of Public Health
l) 1 member Healthwatch
m) 1 member Voluntary Community and Social Enterprise
n) 5 members Place
o) Director of Strategy and Partnerships
p) Director of People

Regular Participants and Observers at Board Meetings

2.9 The Board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit.

2.10 Participants will receive advanced copies of the notice, agenda and papers for Board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote. The following may be invited as Participants:

- The Chair of the Integrated Care Partnership
- A representative of the West Yorkshire Race Equality Network (**DN – To review how other groups are represented)**
- Subject matter experts as required
- Any other person that the Chair considers can contribute to the matter under discussion.

2.11 Participants may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the Standing Orders.

3. Appointments Process for the Board[4]

3.1 Eligibility Criteria for Board Membership:

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test"
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.
d) Commit to behave consistently as leaders and colleagues in ways which model and promote the shared values set out in paragraph 1.1.21.

3.2 Disqualification Criteria for Board Membership

3.2.1 A Member of Parliament~~, or member of the London Assembly~~.

3.2.2 ~~A member of a local authority in England and Wales or of an equivalent body in Scotland or Northern Ireland.~~

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

3.2.4 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted—

a) in the United Kingdom of any offence, or
b) 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.

3.2.5 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

[4] The constitution and our detailed arrangements are subject to legislation, regulations and guidance from NHS England. To ensure that we are able to establish the ICB as a statutory organisation from 1st April, and to comply with national recruitment processes, we will be progressing appointments to ICB posts.

to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.6 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.

3.2.7 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:

a) 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
b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings,
c) 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, or
d) of misbehaviour, misconduct or failure to carry out the person's duties;

3.2.8 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—

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
b) the person's erasure from such a register, where the person has not been restored to the register
c) 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, or
d) 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.

3.2.9 A person who is subject to—

a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.10 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.

3.2.11 A person who has at any time been removed, or is suspended, from the management or control of any body under—

a) 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), or
b) 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).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria

a) The Chair will be independent.

3.3.3 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 3.2 apply.
c) Any other criteria set out in NHS England guidance apply

3.3.4 The term of office for the Chair will be 3 years and the total number of terms a Chair may serve is 3 terms.

3.4 Chief Executive

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

3.4.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England

3.4.3 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

3.4.4 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) Subject to clause 3.4.3(a), they hold any other employment or executive role
c) Any other criteria set out in NHS England guidance apply

3.5 Partner Members - NHS Trusts and Foundation Trusts

3.5.1 These Partner Members are jointly nominated by the Partners which provide services within the area and are of a *description to be inserted in accordance with the regulations, (not yet available). Eligible trusts are likely to be those listed*: Those trusts are:

a) Airedale NHS Foundation Trust
b) Bradford District Care NHS Foundation Trust
c) Bradford Teaching Hospitals NHS Foundation Trust
d) Calderdale and Huddersfield NHS Foundation Trust
e) Harrogate and District NHS Foundation Trust1
f) Leeds and York Partnership NHS Foundation Trust
g) Leeds Community Healthcare NHS Trust
h) The Leeds Teaching Hospitals NHS Trust
i) The Mid Yorkshire Hospitals NHS Trust
j) South West Yorkshire Partnership NHS Foundation Trust
k) Yorkshire Ambulance Service NHS Trust

3.5.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an Executive Director of one of the NHS Trusts or FTs within the ICB's area as listed at 3.5.1.
b) Agree that they will bring knowledge and perspective from their sector but not be delegates or carry agreed mandates from any part of that sector.
c) Declare themselves willing to serve as a full member of a unitary board, inter alia responsible for stewardship of NHS funds and be bound by individual and collective accountability for decisions
d) One shall bring the perspective of NHS Trusts or FTs providing acute services

b) One shall bring the perspective of NHS Trusts or FTs trusts providing mental health, learning disability and autism services.

c) ~~One shall bring the perspective of NHS Trusts or FTs providing community services.~~

3.5.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply

b) Any other criteria set out in NHS England guidance apply.

3.5.4 These members will be appointed by a process arranged by the Chief Executive and will be subject to the approval of the Chair. All appointments will be accordance with agreed ICB policies and national regulations and will take into account national guidance.

3.5.5 The appointment process will be as follows:

a) **Nominations** - NHS Trusts and Foundation Trusts listed at 3.5.1 that provide ~~acute, mental health and community~~ services within the ICB area and are of a description prescribed in the Regulations shall jointly nominate eligible candidates to the Chief Executive, having regard to the ICB's commitment to improve the diversity of its leadership

a) **Appointment** – all eligible candidates shall be subject to an appointment process which will be convened by the Chief Executive and include a representative of each place. The process shall assess candidates against the eligibility criteria set out in para 3.1.1. It shall have regard to the ICB's commitment to improve the diversity of its leadership and to ensuring effective representation across places. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

3.5.6 The term of office for this Partner Member will be 3 years and the total number of terms they may serve is 3 terms.

3.5.7 Subject to satisfactory appraisal, the Chair may approve the re-appointment of the NHS trust and FT partner members up to the maximum number of terms permitted for their role.

3.6 Partner Member - Providers of Primary Medical Services.

3.6.1 This Partner Member is jointly nominated by providers of primary medical services for the purposes of the health service within the Integrated Care Board's area and (ii) are (*Regulations still to be confirmed but likely to*

specify that any holder of a contract for core primary care services who also holds a list of registered patients will be included as a Partner and be eligible to take part in the nomination process.

3.6.2 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be a general practitioner who provides primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract in the ICB area.

b) Agree that they will bring knowledge and perspective from their sector but not be delegates or carry agreed mandates from any part of that sector.

c) Declare themselves willing to serve as a full member of a unitary board, inter alia responsible for stewardship of NHS funds and be bound by individual and collective accountability for decisions

3.6.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

b) Any other criteria set out in NHS England guidance apply.

3.6.4 This member will be appointed by a process arranged by the Chief Executive and will be subject to the approval of the Chair. All appointments will be accordance with agreed ICB policies and national regulations and will take into account national guidance.

3.6.5 The appointment process will be as follows:

b) **Nominations** Qualifying Primary Medical Services providers shall either self-nominate or nominate another eligible Primary Medical Services provider to the Chair of the ICB. Nominations must be supported by a proposer and seconder from within the PMS provider community in the ICB area. ~~shall be by the short listing of eligible candidates in response to an external advertisement. The shortlisting shall be carried out by a panel including a Clinical Director from each of the Primary Care Networks in each place and shall have regard to the ICB's commitment to improve the diversity of its leadership~~

c) **Appointment –** all eligible candidates shall be subject to an appointment process which will be convened by the Chief Executive and include a primary care Clinical Director from ~~representative from~~ each place. The process shall assess candidates against the eligibility criteria set out in para 3.1.1. and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

3.6.6 The term of office for this Partner Member will be 3 years and the total number of terms they may serve is 3 terms.

3.6.7 Subject to satisfactory appraisal, the Chair may approve the re-appointment of the primary medical services partner member up to the maximum number of terms permitted for their role.

3.7 Partner Member - local authorities

3.7.1 This Partner Member is jointly nominated by the ~~*description to be inserted in accordance with the regulations, which are not yet available* from~~ the local authorities whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) City of Bradford Metropolitan District Council
b) Calderdale Council
c) Craven District Council
d) Kirklees Council
e) Leeds City Council
f) North Yorkshire County Council
g) Wakefield Council

3.7.2 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.7.1
b) Be from a local authority listed at 3.7.1 which has statutory social care responsibility.
c) Agree that they will bring knowledge and perspective from their sector but not be delegates or carry agreed mandates from any part of that sector.
d) Declare themselves willing to serve as a full member of a unitary board, inter alia responsible for stewardship of NHS funds and be bound by individual and collective accountability for decisions

3.7.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) Any other criteria set out in NHS England guidance apply

3.7.4 This member will be appointed by a process arranged by the Chief Executive and will be subject to the approval of the Chair. All appointments will be accordance with agreed ICB policies and national regulations and will take into account national guidance

3.7.5 The appointment process will be as follows:

a) **Nominations** – the local authorities whose areas coincide with, or include the whole or any part of, the ICB's area shall nominate eligible candidates to the Chief Executive, having regard to the ICB's commitment to improving the diversity of its leadership.

d) **Appointment** – all eligible candidates shall be subject to an appointment process which will be convened by the Chief Executive and include a representative from each place. The process shall assess candidates against the eligibility criteria set out in para 3.1.1. and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

3.7.6 The term of office for this Partner Member will be 3 years and the total number of terms they may serve is 3 terms.

3.7.7 Subject to satisfactory appraisal, the Chair may approve the re-appointment of the local authority partner up to the maximum number of terms permitted for their role.

3.8 Medical Director

3.8.1 This member will fulfil the eligibility criteria set out at 3.1 and also 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

b) Be a registered Medical Practitioner

3.8.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply

b) Any other criteria set out in NHS England guidance apply.

3.8.3 This member will be appointed by a process arranged by the Chief Executive and will be subject to the approval of the Chair. All appointments will be in accordance with agreed ICB policies and national regulations and will take into account national guidance.

3.8.4 The appointment process will be as follows:

a) **Nominations** – shall be by the short listing of eligible candidates in response to an external advertisement. The shortlisting shall be carried out by a panel convened by the Chief Executive.

b) **Appointment** - all eligible candidates shall be subject to an appointment process which will be convened by the Chief Executive. The process shall assess candidates against the eligibility criteria set out in para 3.1.1. and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

3.9 Director of Nursing

3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also 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

b) Be a registered Nurse

3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply

b) Any other criteria set out in NHS England guidance apply.

3.9.3 This member will be appointed by a process arranged by the Chief Executive and will be subject to the approval of the Chair. All appointments will be accordance with agreed ICB policies and national regulations and will take into account national guidance.

3.9.4 The appointment process will be as follows:

a) **Nominations** – shall be by the short listing of eligible candidates in response to an external advertisement. The shortlisting shall be carried out by a panel convened by the Chief Executive.

b) **Appointment** - all eligible candidates shall be subject to an appointment process which will be convened by the Chief Executive. The process shall assess candidates against the eligibility criteria set out in para 3.1.1. and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the

process. The appointment will be subject to the approval of the Chair.

3.10 Director of Finance

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also 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
b) Be a qualified accountant.

3.10.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Any other criteria set out in NHS England guidance apply.

3.10.3 This member will be appointed by a process arranged by the Chief Executive and will be subject to the approval of the Chair. All appointments will be accordance with agreed ICB policies and national regulations and will take into account national guidance.

3.10.4 The appointment process will be as follows:

a) **Nominations** – shall be by the short listing of eligible candidates in response to an external advertisement. The shortlisting shall be carried out by a panel convened by the Chief Executive.
b) **Appointment** - all eligible candidates shall be subject to an appointment process which will be convened by the Chief Executive. The process shall assess candidates against the eligibility criteria set out in para 3.1.1. and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

3.11 Four~~Three~~ Independent Non-Executive Members

3.11.1 The ICB will appoint four ~~three~~ independent Non-Executive Members. One of these members shall be appointed by the Chair as the senior independent member.

3.11.2 These members will be appointed by a process arranged by the Chief Executive and will be subject to the approval of the Chair. All appointments will be accordance with agreed ICB policies and national regulations and will take into account national guidance

3.11.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Not be 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 and Nomination Committee

3.11.4 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) They hold a role in another health and care organisation within the ICB area
c) Any other criteria set out in NHS England guidance apply.

3.11.5 The appointment process will be as follows:

a) **Nominations** – shall be by the short listing of eligible candidates in response to an external advertisement. The shortlisting shall be carried out by a panel convened by the Chief Executive.
e) **Appointment** – all eligible candidates shall be subject to an appointment process which will be convened by the Chief Executive and include a representative from each place. The process shall assess candidates against the eligibility criteria set out in para 3.1.1. and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

3.11.6 The term of office for an independent non-executive member will be 3 years and the total number of terms an individual may serve is 3 terms, after which they will no longer be eligible for re-appointment.

3.11.7 Initial appointments may be for a shorter period 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.

3.11.8 Subject to satisfactory appraisal, the Chair may approve the re-appointment of an independent non-executive member up to the maximum number of terms permitted for their role.

3.12 Other board members

3.13 Five Members – Place-based Partnerships

3.13.1 These Members will bring the perspective of the place-based partnerships in:

a) Bradford District and Craven
b) Calderdale
c) Kirklees
d) Leeds
e) Wakefield

3.13.2 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be a senior leader of a partner organisation in a place-based partnership.
b) Specify any other criteria agreed locally by the ICB

3.13.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) Any other criteria set out in NHS England guidance apply.

3.13.4 Initially, these members shall either be those senior leaders from each place who have been appointed as Place Directors through an agreed organisational change process or where a place does not have a Place Director role, shall be another nominated senior leader representative of the place.

3.13.5 Subsequently, when a vacancy arises, these members will be appointed by a process arranged by the Chief Executive and will be subject to the approval of the Chair. All appointments will be accordance with agreed ICB policies and national regulations and will take into account national guidance.

3.13.6 The appointment process will be as follows:

a) **Nominations** – each of the place-based partnerships set out at 3.13.1 shall nominate eligible candidates to the Chief Executive, having regard to the ICB's commitment to improving the diversity of its leadership.
b) **Appointment** – all eligible candidates shall be subject to an appointment process which will be convened by the Chief Executive. The process shall assess candidates against the eligibility criteria set out in para 3.1.1. and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

3.14 Member - Director of Public Health

3.14.1 This member will bring the perspective of Directors of Public Health from the local authorities with responsibilities for public health whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) City of Bradford Metropolitan District Council
b) Calderdale Council
c) Kirklees Council
d) Leeds City Council
e) North Yorkshire County Council
f) Wakefield Council

3.14.2 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be the Director of Public Health of one of the bodies listed at 3.7.1
b) Agree that they will bring knowledge and perspective from their sector but not be delegates or carry agreed mandates from any part of that sector.
c) Declare themselves willing to serve as a full member of a unitary board, inter alia responsible for stewardship of NHS funds and be bound by individual and collective accountability for decisions

3.14.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) Any other criteria set out in NHS England guidance apply.

3.14.4 This member will be appointed by a process arranged by the Chief Executive and will be subject to the approval of the Chair. All appointments will be accordance with agreed ICB policies and national regulations and will take into account national guidance.

3.14.5 The appointment process will be as follows:

a) **Nominations** – the local authorities whose areas coincide with, or include the whole or any part of, the ICB's area shall nominate eligible candidates to the Chief Executive, having regard to the ICB's commitment to improving the diversity of its leadership.
b) **Appointment** – all eligible candidates shall be subject to an appointment process which will be convened by the Chief Executive and include a representative of each place. The process shall assess candidates against the eligibility criteria set out in para 3.1.1. and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

3.14.6 The term of office for this Member will be 3 years and the total number of terms they may serve is 3 terms.

3.14.7 Subject to satisfactory appraisal, the Chair may approve the re-appointment of the local authority partner up to the maximum number of terms permitted for their role.

3.15 Member – community services

3.15.1 This member is jointly nominated by the organisations which provide community services within the ICB area. Those organisations are (**DN: To be defined in line with the Regulations for NHS trusts and also to include other providers of community services)**

3.15.2 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an Executive Director of one of the organisations listed at 3.15.1 providing community services within the ICB's area.

b) Agree that they will bring knowledge and perspective from their sector but not be delegates or carry agreed mandates from any part of that sector.

c) Declare themselves willing to serve as a full member of a unitary board, inter alia responsible for stewardship of NHS funds and be bound by individual and collective accountability for decisions

3.15.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply.

b) Any other criteria set out in NHS England guidance apply.

3.15.4 This member will be appointed by a process arranged by the Chief Executive and will be subject to the approval of the Chair. All appointments will be accordance with agreed ICB policies and national regulations and will take into account national guidance.

3.15.5 The appointment process will be as follows:

a) **Nominations** – the providers of community services listed at 3.15.1 shall jointly nominate eligible candidates to the Chief Executive, having regard to the ICB's commitment to improve the diversity of its leadership

b) **Appointment –** all eligible candidates shall be subject to an appointment process which will be convened by the Chief Executive and include a representative from each place. The process shall assess candidates against the eligibility criteria set out in para 3.1.1. and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

3.15.6 The term of office for this Member will be 3 years and the total number of terms they may serve is 3 terms.

3.15.7 Subject to satisfactory appraisal, the Chair may approve the re-appointment of the community services member up to the maximum number of terms permitted for their role.

3.16 Member - Voluntary, community and social enterprise sector

3.16.1 This Member will bring the perspective of ~~organisations from~~ the voluntary, community and social enterprise sector (VCSE) and specifically those organisations which contribute to the ~~which provide~~ health, social ~~and~~ care and wellbeing of people ~~services~~ in the ICB area.

3.16.2 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

d) Be a person currently working in a senior leadership role in the VCSE ~~of a voluntary, community and social enterprise~~ sector (paid or unpaid) in West Yorkshire with extensive experience and knowledge of the wider sector , and a good understanding of the current context of health and care across West Yorkshire.~~which provide health and care services in the ICB area~~.

e) Agree that they will bring knowledge and perspective from their sector but not be delegates or carry agreed mandates from any part of that sector.

f) Declare themselves willing to serve as a full member of a unitary board, inter alia responsible for stewardship of NHS funds and be bound by individual and collective accountability for decisions

3.16.3 Individuals will not be eligible if

c) Any of the disqualification criteria set out in 3.2 apply.

d) Any other criteria set out in NHS England guidance apply.

3.16.4 This member will be appointed by a process arranged by the Chief Executive and will be subject to the approval of the Chair. All appointments will be accordance with agreed ICB policies and national regulations and will take into account national guidance.

3.16.5 The appointment process will be as follows:

c) **Nominations** shall be by the short listing of eligible candidates in response to an external advertisement. The shortlisting shall be carried out by a panel including a VCSE representative from each of the places set out at 3.13.1 and shall have regard to the ICB's commitment to improve the diversity of its leadership

d) **Appointment –** all eligible candidates shall be subject to an appointment process which will be convened by the Chief Executive and include a representative from each place. The process shall assess candidates against the eligibility criteria set out in para 3.1.1. and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

3.16.6 The term of office for this Member will be 3 years and the total number of terms they may serve is 3 terms.

3.16.7 Subject to satisfactory appraisal, the Chair may approve the re-appointment of the VCSE partner member up to the maximum number of terms permitted for their role.

3.17 Member - Healthwatch

3.17.1 This Member will bring the perspective of all Healthwatch organisations in the ICB area.

3.17.2 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be a senior leader of a Healthwatch organisation in the ICB area.
b) Agree that they will bring knowledge and perspective from their sector but not be delegates or carry agreed mandates from any part of that sector.
c) Declare themselves willing to serve as a full member of a unitary board, inter alia responsible for stewardship of NHS funds and be bound by individual and collective accountability for decisions

3.17.3 Individuals will not be eligible if
a) Any of the disqualification criteria set out in 3.2 apply
b) Any other criteria set out in NHS England guidance apply.

3.17.4 This member will be appointed by a process arranged by the Chief Executive, subject to the approval of the Chair. All appointments will be accordance with agreed ICB policies and national regulations and will take into account national guidance.

3.17.5 The appointment process will be as follows:
a) **Nominations** the Healthwatch organisations whose areas coincide with, or include the whole or any part of, the ICB's area shall nominate eligible candidates to the Chief Executive, having regard to the ICB's commitment to improving the diversity of its leadership.
b) **Appointment –** all eligible candidates shall be subject to an appointment process which will be convened by the Chief Executive and include a representative from each place. The process shall assess candidates against the eligibility criteria set out in para 3.1.1. and shall have regard to the ICB's commitment to improve the diversity of its leadership. The appointment will be subject to the approval of the Chair.

3.17.6 The term of office for this Member will be 3 years and the total number of terms they may serve is 3 terms.

3.17.7 Subject to satisfactory appraisal, the Chair may approve the re-appointment of the Healthwatch partner Member up to the maximum number of terms permitted for their role.

3.18 Director of People

3.18.1 This member will fulfil the eligibility criteria set out at 3.1 and also 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

3.18.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Any other criteria set out in NHS England guidance apply.

3.18.3 This member will be appointed by a process arranged by the Chief Executive and will be subject to the approval of the Chair. All appointments will be accordance with agreed ICB policies and national regulations and will take into account national guidance.

3.18.4 The appointment process will be as follows:

a) **Nominations** – shall be by the short listing of eligible candidates in response to an external advertisement. The shortlisting shall be carried out by a panel convened by the Chief Executive.

b) **Appointment** - all eligible candidates shall be subject to an appointment process which will be convened by the Chief Executive. The process shall assess candidates against the eligibility criteria set out in para 3.1.1. and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

3.19 Director of Strategy and Partnerships

3.19.1 This member will fulfil the eligibility criteria set out at 3.1 and also 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.

3.19.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply

b) Any other criteria set out in NHS England guidance apply.

3.19.3 This member will be appointed by a process arranged by the Chief Executive and will be subject to the approval of the Chair. All appointments will be accordance with agreed ICB policies and national regulations and will take into account national guidance.

3.19.4 The appointment process will be as follows:

a) **Nominations** – shall be by the short listing of eligible candidates in response to an external advertisement. The shortlisting shall be carried out by a panel convened by the Chief Executive.

b) **Appointment** - all eligible candidates shall be subject to an appointment process which will be convened by the Chief Executive. The process shall assess candidates against the eligibility criteria set out in para 3.1.1. and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

3.20 Board Members: Removal from Office.

3.20.1 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.

3.20.2 With the exception of the Chair, Board members 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 they fail to attend three consecutive meetings unless agreed with the Chair in extenuating circumstances
c) If they are deemed to not meet the expected standards of performance at their annual appraisal.
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to failing to meet the ICB standards of business conduct; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a

decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise: gross misconduct.

e) Are deemed to have failed to uphold the Nolan Principles of Public Life
f) Are subject to disciplinary proceedings by a regulator or professional body

3.20.3 Members may be suspended pending the outcome of an investigation arranged by the Chief Executive into whether any of the matters in 3.13.3 apply.

3.20.4 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.

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

3.20.6 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.

3.21 Terms of Appointment of Board Members

3.21.1 With the exception of the Chair , arrangements for remuneration and any allowances will be agreed by the Remuneration and Nomination Committee in line with the ICB remuneration policy and any other relevant policies published [say where] and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England.

3.21.2 Other terms of appointment will be determined by the Remuneration and Nomination Committee.

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

3.22 Specific arrangements for appointment of Ordinary Members made at establishment

3.22.1 Individuals may be identified as "designate ordinary members" prior to the ICB being established.

3.22.2 Relevant nomination procedures for partner members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the provisions of 3.5-3.7 and the nominating organisations (as set out in clauses 3.5-3.7) have confirmed their nominations following the Health and Care Bill receiving Royal Assent

3.22.3 Any appointment and assessment processes undertaken in advance of establishment to identify designate ordinary members should follow, as far as possible, the processes set out in section 3.5-3.12 of this constitution. However, a modified process, agreed by the Chair, will be considered valid.

3.22.4 On the day of establishment, a committee consisting of the Chair, Chief Executive and [one other] will appoint the ordinary members who are expected to be all individuals who have been identified as designate appointees pre ICB establishment and the Chair will approve those appointments.

3.22.5 For the avoidance of doubt, this clause is valid only in relation to the appointments of the initial ordinary members and all appointments post establishment will be made in accordance with clauses 3.5 to 3.12.

3.23 Review of Board size and composition

3.20.1 In view of the appointment of additional board members to address the size and complexity of the ICS, an annual review of board size and composition will be carried out to ensure that the board is fit for purpose and meets good governance standards. Any necessary changes will be proposed thereafter.

4. Arrangements for the Exercise of our Functions.

4.1 Good Governance

4.1.1 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.

4.1.2 The ICB has agreed a Standards of Business Conduct policy 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 governance standards and principles that will guide decision making in the ICB. The ICB code of conduct, governance standards and behaviours are published in the Governance Handbook.

4.1.3 There will be a formal and rigorous annual evaluation of the performance of the Board, its Committees, the Chair and individual Directors. The annual evaluation of the Board will consider its composition, diversity and how effectively members work together to achieve objectives. Individual evaluation will demonstrate whether each Director continues to contribute effectively.

4.2 General

4.2.1 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; and
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

4.2.2 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.

4.3 Authority to Act

4.3.1 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

4.3.2 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.

4.3.3 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.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full [add where]

4.4.2 Only the Board may agree the SoRD and amendments to the SoRD may only be approved by the Board

4.4.3 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

4.4.4 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.

4.5 Functions and Decision Map

4.5.1 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.

4.5.2 The Functions and Decision Map is published [add web address]

4.5.3 The 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).

4.6 Committees and Sub-Committees

4.6.1 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.

4.6.2 In line with the ICB's principles of subsidiarity, the ICB has established committees in each of its places (Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield. These committee have delegated authority from the Board to make decisions about ICB functions and resources at place level as set out in the SoRD. All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee established by the ICB operates under terms of reference and membership agreed by the Board. All terms of reference are published in the Governance Handbook[5].

4.6.4 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:

[5] Under development.

a) operate within its terms of reference. For committees, these will be approved by the Board and for sub-committees these will be approved by the parent committee.

b) have due regard to and operate within the Constitution, standing orders, standing financial instructions and other financial procedures of the ICB.

c) submit their minutes to each formal Board meeting or, in the case of sub committees, to its parent committee.

d) publish their minutes on the ICB website once ratified.

e) draw to the attention of the Board or parent committee any significant risks.

f) undertake an annual self-assessment of their own performance. This self-assessment shall form the basis of the annual report from the committee or sub committee.

g) submit an annual report to the Board or parent Committee.

h) members will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct

i) 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

j) commit to behave consistently as leaders and colleagues in ways which model and promote the shared values set out in paragraph 1.1.21.

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of, or include, persons who are not ICB Members or employees.

4.6.6 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.

4.6.7 The following committees will be maintained:

a) Audit Committee: 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 and Nomination Committee: This committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration and Nomination Committee will be chaired by an independent non-executive member other than the Chair or the Chair of Audit Committee.

4.6.8 The terms of reference for each of the above committees are published in the governance handbook.

4.6.9 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 in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 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).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. 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.

4.7.4 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.

4.7.5 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.

5. Procedures for Making Decisions

5.1 Standing Orders

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

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

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the Board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and forms part of this constitution.

5.2 Standing Financial Instructions (SFIs)[6]

5.2.1 The ICB has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs published in the governance handbook.

[6] Standing Financial Instructions are under development.

6. Arrangements for Conflict of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest

[Subject to change in line with NHS England guidance]

6.1.1 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.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the website

6.1.3 All Board, committee and sub-committee members, 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.

6.1.4 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.

6.1.5 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.

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

a) Act as a conduit for members of the public and members of the partnership 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.

6.2 Principles

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

a) Recognising that the perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them actually occurring. If in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it. For a conflict of interest to exist, financial gain is not necessary.

b) Doing business appropriately – conflicts of interest become much easier to identify, avoid and/or manage when the processes for needs assessments, consultation mechanisms, commissioning strategies and procurement procedures are right from the outset, because the rationale for all decision-making will be clear and transparent and should withstand scrutiny.

c) Being proactive, not reactive – the ICB will seek to identify and minimise the risk of conflicts of interest at the earliest possible opportunity for instance by considering potential conflicts of interest when appointing individuals to join the Board or other decision-making bodies, and by ensuring individuals receive proper induction and understand their obligations to declare conflicts of interest.

d) Being balanced, appropriate and proportionate to the circumstances and context – rules will be clear and robust but not overly prescriptive or restrictive. They should ensure that decision-making processes are transparent and fair whilst not being overly constraining, complex or cumbersome.

e) Being transparent – the ICB will document the approach and decisions taken at every stage in the decision-making process so that a clear audit trail is evident.

f) Creating an environment and culture where individuals feel supported and confident in declaring relevant information and raising any concerns.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

a) Members of the ICB
b) Members of the Board's committees and sub-committees

c) Its employees

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB website /add where.

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 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 and discussed on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1

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

6.3.7 Interests (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.

6.3.8 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.

6.4 Standards of Business Conduct

6.4.1 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.

6.4.2 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.

7. Arrangements for ensuring Accountability and Transparency

7.0 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.

7.1 Principles

7.1.1 We will

a) provide information that is clear and easy to understand, free of jargon and in plain language;
b) be timely, targeted and proportionate in how we communicate and engage;
c) foster good relationships and trust by being open, honest and accountable;
d) ask people what they think and listen to their views;
e) talk to our communities including those most likely to be affected by any change;
f) provide feedback about decisions and explain how public and stakeholder views have had an impact;
g) work in partnership with other organisations in West Yorkshire;
h) use resources well to make sure we get the most out of what we have;
i) review and evaluate our work, using learning to make improvements.

7.2 Meetings and publications

7.2.1 Board meetings and committees composed entirely of board members or which include all board members will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

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

7.2.3 Annual accounts will be externally audited and published.

7.2.4 A clear complaints process will be published.

7.2.5 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.

7.2.6 information will be provided to NHS England as required.

7.2.7 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
c) Standards of Business Conduct

7.2.8 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:

- section 14Z34 (improvement in quality of services),
- section 14Z35 (reducing inequalities),
- section 14Z43 (have regard to effect of decisions)
- section 14Z44 (public involvement and consultation), and
- sections 223H and 223J (financial duties).

And

7.2.9 proposed steps to implement the joint local health and wellbeing strategies of the Health and Wellbeing Boards in Bradford District and Craven, Calderdale, Kirklees, Leeds, North Yorkshire and Wakefield.

7.3 Scrutiny and Decision Making

7.3.1 At least three independent non-executive members will be appointed to the board including the Chair; and 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.

7.3.2 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.

7.3.3 The ICB will comply with the requirements of the NHS Provider Selection Regime[7] including:

a) evidencing that it has properly exercised the responsibilities conferred on it by the regime by:
   - publishing the intended selection approach and the relative importance of all material selection criteria in advance.
   - publishing the outcome of decisions made and the details of contracts awarded.
   - keeping a record of decisions made under the regime, including evidence that all relevant issues and criteria have been considered and that the reasons for any decision are clearly justified.
   - recording how conflicts of interest were managed

b) monitoring compliance with this regime via an annual internal audit processes the results of which will be published.

c) including in the annual report a summary of contracting activity as specified by the regime.

d) ensuring that appropriate internal governance mechanisms are in place to deal with representations made against provider selection decisions and that any such representations are considered fairly and impartially within the timescales prescribed.

7.3.4 The ICB will comply with local authority health overview and scrutiny requirements, including joint overview and scrutiny arrangements.

7.4 Annual Report

7.4.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it 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), and

7.4.2 The annual report will also review the extent to which the ICB has exercised its functions in accordance with the plans published under section

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

[7] Subject to regulations that are not yet published.

7.4.3 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.

8. Arrangements for Determining the Terms and Conditions of Employees.

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

8.2 The Board has established a Remuneration and Nomination Committee which is chaired by a Non-Executive member other than the Chair or Audit Chair.

8.3 The membership of the Remuneration and Nomination Committee is determined by the Board. No employees may be a member of the Remuneration and Nomination Committee but the Board ensures that the Remuneration and Nomination Committee has access to appropriate advice by ensuring that human resource advisers are in attendance and that the committee has access to appropriate expertise.

8.4 The Board may appoint independent members or advisers to the Remuneration and Nomination Committee who are not members of the board.

8.5 The main purpose of the Remuneration and Nomination Committee is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published say where.

8.6 The duties of the Remuneration and Nomination Committee include:

a) Setting the ICB pay policy (or equivalent) and standard terms and conditions
b) Making arrangements to pay employees such remuneration and allowances as it may determine, aligning ICB remuneration with that of NHS partners in the West Yorkshire Integrated Care System
c) Setting remuneration and allowances for members of the board
d) Setting any allowances for members of committees or sub-committees of the ICB who are not members of the board
e) Ensuring that there is a formal, rigorous and transparent procedure for the recruitment and appointment of employees and members of the Integrated Care Board including effective succession planning.
f) Any other relevant duties.

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

9. Arrangements for Public Involvement

9.1 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.

9.2 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) To ensure that the plan reflects the views of local people we will carry out engagement and involvement activities which may include surveys and focus groups.
b) This will sit alongside an engagement and consultation mapping report which will set out the work that has taken place in our local places and at West Yorkshire level.
c) We will have regard to NHS Guidance on consultation and engagement. The ten principles set out by NHS England and our local principles will also apply.

9.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities.

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.

9.3.2 In addition, the ICB has agreed the following communication and involvement principles. All such activity carried out by and on behalf of the ICB will be:

a) Accessible and inclusive – to all our audiences. For example, involving people at a time and place that is convenient to them, and establishing environments and methods that make it easy for people to be open with their input.

b) Informed by data – we will use insight and evidence to target and inform Involvement work to develop plans.

c) Clear and concise – allowing messages to be easily understood by all

d) Communications will be available in different formats - not everyone has the digital skills or confidence to access online information so information in other formats must be available if preferred. We will always communicate in Plain English. Acronyms will be clearly explained, we will reduce the use of jargon and we will write in clear and concise terms so that everyone can understand what we are saying.

e) Consistent and accountable – in line with our vision, messages, and purpose

f) Flexible – ensuring communications and involvement activity follows a variety of formats, tailored to and appropriate for each audience

g) Open, honest, and transparent – we will be clear from the start of the conversations what our plans are, what is and what isn't negotiable, the reasons why and ultimately, how decisions will be made

h) Targeted – making sure we get messages to the right people and in the right way

i) Timely – making sure people have enough time to respond and are kept updated

j) Two-way – we will listen and respond accordingly, letting people know the outcome of all conversations.

k) Value for money – we will use our available resources and skills creatively and effectively

9.3.3 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.3.4 The ICB has agreed a set of arrangements for engaging with people and communities which are set out in the Communication and Involvement Framework (insert link)

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.
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this constitution
Board (ICB Board)	The decision-making body of the ICB at West Yorkshire level.
Committee	A committee created and appointed by the ICB Board.
Health and Wellbeing Board	A statutory committee of a local authority (at place level) which brings together leaders from the local health and care system. Responsible for producing a joint strategic needs assessment and a joint health and wellbeing strategy.
Health Overview and Scrutiny Committee	A statutory committee of a local authority that undertakes in-depth reviews of health and care issues for local people. There are overview and scrutiny committees at place and West Yorkshire level.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
Integrated Care Partnership (ICP)	The joint committee of 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.
Integrated Care System (ICS)	The whole health and care system across West Yorkshire known as the West Yorkshire Health and Care Partnership. The ICS is made up of the NHS, councils, Healthwatch and the voluntary, community and social enterprise sector (VCSE) partners in each of our places (Bradford District and Craven; Calderdale, Kirklees, Leeds and Wakefield) and across West Yorkshire.
Partnership	The West Yorkshire Health & Care Partnership (the ICS).

Place-based Integrated Care Board Committee (Place ICB Committee)	The formal decision-making committee which brings together health, care, VSCE and Healthwatch partners to make decisions about ICB functions and resources at place level. Formally established by the ICB, with delegated authority to make decisions in accordance with the SoRD.
Place	The geographical level at which most of the work to join up health and care services happens. Our places are: Bradford District and Craven; Calderdale, Kirklees, Leeds, and Wakefield,
Place-Based Partnership	Collaborative arrangements formed by organisations responsible for arranging and delivering health and care services in our places. They involve the ICB local authorities and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities.
Provider collaborative	NHS trusts working together to achieve better outcomes for people and ensure sustainable services in the future. Provider collaboratives work at both place and West Yorkshire level
Ordinary Member	The Board will have a Chair and a Chief Executive plus other members. All other members of the Board are referred to as Ordinary Members.
Sub-Committee	A committee created and appointed by and reporting to a committee.
	ICBs should add local definitions as required and should always include any local terms that refer to legally prescribed roles or functions.

Appendix 2: Standing Orders

1. Introduction

1.1 These Standing Orders have been drawn up to regulate the proceedings of NHS West Yorkshire Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.

2. Amendment and review

2.1 The Standing Orders are effective from xx

2.2 Standing Orders will be reviewed on an annual basis or sooner if required.

2.3 Amendments to these Standing Orders will be made as per clause 1.6 in this constitution.

2.4 All changes to these Standing Orders will require an application to NHS England for variation to the ICB constitution and will not be implemented until the constitution has been approved.

3. Interpretation, application and compliance

3.1 Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2 These standing orders apply to all meetings of the Board, including its committees and sub-committees unless otherwise stated. All references to Board are inclusive of committees and sub-committees unless otherwise stated.

3.3 All members of the Board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4 In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from [add title for senior governance adviser,] will provide a settled view which shall be final.

3.5 All members of the Board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6 If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next

formal meeting of the Board for action or ratification and the Audit Committee for review.

4. Meetings of the Integrated Care Board

4.1 Calling Board Meetings

4.1.1 Meetings of the Board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2 In normal circumstances, each member of the Board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.

b) One third of the members of the Board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the Board specifying the matters to be considered at the meeting.

c) In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3 A public notice of the time and place of ~~the~~ meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least seven ~~three~~ clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2 Chair of a meeting

4.2.1 The Chair of the ICB shall preside over meetings of the Board.

4.2.2 If the Chair is absent, or is disqualified from participating by a conflict of interest, the Deputy Chair will chair the meeting. The Deputy Chair will be the senior independent non-executive member. In the absence of the Chair

and the Deputy Chair, the Chair will be an independent non-executive member, appointed by the assembled members.

4.2.3 The Board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the Board at least five calendar days before the meeting.

4.3.3 Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at [insert link].

4.4 Petitions

4.4.1 Where a petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the Board in accordance with the ICB policy as published in the Governance Handbook.

4.5 Nominated Deputies

4.5.1 With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the Board may nominate a deputy to attend a meeting of the Board that they are unable to attend. Members should inform the Chair of their intention to nominate a deputy and should ensure that any such deputy is suitable briefed and qualified to act in that capacity. The deputy may speak and vote on their behalf.

4.5.2 The decision of person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6 Virtual attendance at meetings

4.6.1 The Board and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this. Arrangements for virtual meetings will

comply with the ICBs transparency principles, including requirements for meetings to be held in public.

4.7 Quorum

4.7.1 The quorum for meetings of the Board will be 12~~1~~ members, including:

a) The Chair or Deputy Chair
b) The Chief Executive or Director of Finance
c) Either the Medical Director or the Director of Nursing
d) At least one independent non executive member
e) At least one Partner member
f) At least one Place Member

4.7.2 For the sake of 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.

4.7.3 For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8 Vacancies and defects in appointments

4.8.1 The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply: where temporary arrangements have been put in place to fill the vacancy or defect, then this individual will count towards the quoracy, including if they are temporarily acting in the roles of those members specifically listed in quoracy requirements (eg. Director of Nursing, Director of Finance). Where temporary arrangements have not been put in place, a reduced quoracy will be proposed to the Board by the Chair and Chief Executive in conjunction with the Chair of the Audit Committee.

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2 Generally it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the Board who are present at the meeting will be eligible to cast one vote each.

b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.

c) For the sake of clarity, any additional Participants (as detailed within paragraph 5.6. of the Constitution) will not have voting rights.

d) A resolution will be passed if more votes are cast for the resolution than against it.

e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.

f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3 if consensus cannot be reached, the chair may make decisions on behalf of the board where there is disagreement. Where necessary boards may draw on third party support such as peer review or mediation by NHS England and NHS Improvement.

Urgent decisions

4.9.4 In the case urgent decisions and extraordinary circumstances, every attempt will be made for the Board to meet virtually. Where this is not possible the following will apply.

4.9.5 The powers which are reserved or delegated to the Board, may for an urgent decision be exercised by the Chair (or Deputy Chair if necessary) and Chief Executive (or relevant lead director in the case of committees). This is subject to every effort having made to consult with as many Board

members as possible in the given circumstances. This will ~~,~~ include the Director of Finance and at least one independent non-executive member.

4.9.6 The exercise of such powers including details of Board members consulted shall be reported to the next formal meeting of the Board for formal ratification and the Audit Committee for oversight.

4.10 Minutes

4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11 Admission of public and the press

4.11.1 In accordance with Public Bodies (Admission to Meetings) Act 1960, all meetings of the Board and all meetings of committees which are comprised of entirely board members or all board members, ~~ICB~~ at which public functions are exercised will be open to the public. Other ICB meetings at which public functions are exercised may also be open to the public.

4.11.2 The Board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Governing Body's business shall be conducted without interruption and disruption.

4.11.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting suppress or prevent disorderly conduct or behaviour.

4.11.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the Board.

5. Suspension of Standing Orders

5.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least 2 other members.

5.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Use of seal and authorisation of documents.

6.1 The ICB may have a seal for executing documents where necessary. The seal will be kept securely in a locked facility. The following are authorised to authenticate its use by their signature:

- The Chief Executive
- The Chair of the ICB
- The Director of Finance

Annex 3

West Yorkshire Integrated Care Board - Governance handbook

DRAFT summary of contents

Content	Status
How we work in West Yorkshire	
• Purpose of handbook and links to constitution	In development.
• Glossary of terms	Expanded version of that included in constitution.
• Scheme of reservation and delegation	Attached – Annex 4.
• Functions and decisions map	Attached – Annex 5.
• ICS governance structure chart	Attached – Annex 6.
• Governance standards	Attached – Annex 7.
• Case studies – how our governance arrangements will work in practice	In development.
Committee Terms of Reference	
• Partnership Board	In draft – reviewed by Partnership Board 7 December 2021.
• Place Committees	In development.
• WY committees ○ Audit ○ Finance, Investment and Performance ○ People ○ Remuneration & Nomination ○ System Quality ○ Transformation	In development.
Key policies and supporting documents	
• Standing financial instructions	In development.
• Conflicts of interest policy	In development.
• Standards of business conduct	In development.

West Yorkshire Integrated Care Board – Scheme of Reservation and Delegation (SoRD)

Note: *All decisions and responsibilities will be carried out with regard to the following ICB function: "Through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensure that the NHS plays a full part in achieving wider goals of social and economic development and environmental sustainability". (Interim Guidance on the functions and governance of the ICB, August 2021)*

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
Regulation and Control				
Constitution 1.6[1]	Consider and approve applications to NHS England on changes to the Constitution	✓		
Constitution 4.6	Establish and approve terms of reference and membership for ICB Committees.[2]	✓		
Constitution 3	Approve the appointment of Board members.			Chair[3]
Constitution 1.7.3	Approve the ICB scheme of reservation and delegation (SoRD) which sets out those decisions reserved to the Board, committees and sub-committees, individuals or specified persons.	✓		
Constitution 1.7.3	Approve the ICB operational scheme of delegation, which sets out those key operational decisions delegated to individuals or specified persons.	✓		
4.9.5	Definition and taking of 'urgent decisions' on behalf of the Board.			Chair, Chief Executive, Director of Finance, Independent Non Executive member

[1] *References are to draft constitution dated 08.11.21*

[2] *As per Standing Order 4.6.6, terms of reference for sub-committees will be approved by the parent committee.*

[3] *The Chief Executive appointment is subject to approval by NHS England.*

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
Constitution 4.7	Agree any functions delegated to other statutory bodies.	✓		
Constitution 1.4	Approve the arrangements for discharging the ICB's functions including but not limited to a) Having regard to and acting in a way that promotes the NHS Constitution b) Exercising its functions effectively, efficiently and economically. c) Duties in relation to children including safeguarding and promoting welfare. d) Adult safeguarding and carers (the Care Act 2014) e) Equality, including the public-sector equality duty f) Information law g) Provisions of the Civil Contingencies Act 2004. h) Improvement in quality of services. i) Reducing inequalities. j) Obtaining appropriate advice. k) Duty to have regard to effect of decisions. l) Public involvement and consultation. m) Financial duties. n) Having regard to assessments and strategies	✓		
Constitution	Exercise or delegate those functions of the ICB which have not been retained as reserved by the ICB Board or delegated to its Committees and sub-committees or delegated to named other individuals as set out in this document.			Chief Executive
ICB 4[4]	Establish 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.	✓	Assured by Finance, Performance and Investment Committee	

[4] *Functions of the ICB as set out in the Interim Guidance on the functions and governance of the ICB - August 2021.*

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
ICB 4	Establish governance arrangements to support collective accountability between partner organisations for place-based system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations.		Place Committees	
	Approve the arrangements for discharging the ICB's statutory financial duties.	✓		
	Approve the ICB's standing financial instructions.	✓	Recommended by Finance Investment and Performance Committee	
	Approve the ICB's corporate budgets and financial plan that meet the ICB's financial duties.	✓		
Annual report and accounts				
Constitution 7.4	Approve the ICB Annual Report and Annual Accounts	✓		
	Approve the timetable for the preparation and approval of the ICB's annual report and annual accounts		Audit Committee	
	Approve the appointment of the ICB's external auditor.	✓		
Strategy and Planning				
ICB 1	Agree a plan to meet the health and healthcare needs of the population within West Yorkshire, having regard to the Partnership integrated care strategy and place health and wellbeing strategies.	✓[5]		
ICB 1	Agree a plan to meet the health and healthcare needs of the population within each place, having regard to the Partnership		Place Committees[6]	

[5] *Informed by Integrated Care Partnership and Health and Wellbeing Boards.*
[6] *Informed by Integrated Care Partnership and Health and Wellbeing Boards.*

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
	integrated care strategy and place health and wellbeing strategies.			
ICB 2	Allocate 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)	✓		
ICB 2	Allocate resources to deliver the plan in each place, determining what resources should be available to meet population need and setting principles for how they should be allocated across services and providers (both revenue and capital)		Place Committees	
ICB 5	Arrange for the provision of health services in line with the allocated resources across the ICS through a range of activities including: a) putting contracts and agreements in place to secure delivery of its plan by providers b) convening and supporting providers (working both at scale and at place) to lead major service transformation programmes to achieve agreed outcomes. c) support the development of primary care networks (PCNs) as the foundations of out-of-hospital care and building blocks of place-based partnerships. including through investment in PCN management support, data and digital capabilities, workforce development and estates. d) working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care	✓ Matters that meet one or more of the '3 tests' for working at scale.	Place Committees	

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
ICB 12	Approve decisions on the review, planning and procurement of primary medical care services (to reflect the terms of the delegation agreement with NHS England). [7]	Matters that meet one or more of the '3 tests' for working at scale.	Place Committees	
	Approve the ICB operating structure.	✓		
	Approve the operating structure in each place.		Place Committees	
ICB 6	Agree system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers.		People Committee	
ICB 6	Agree implementation in place of people priorities.		Place Committees	
ICB 7	Agree 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.	✓[8]		
ICB 7	Agree place 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.		Place Committees	
ICB 10	Agree joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across West	✓		

[7] *Delegation agreement not published as at 16.02.22.*

[8] *As recommended by Digital Board*

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
	Yorkshire and support wider goals of development and sustainability.			
ICB 10	Agree joint work on estates, procurement, supply chain and commercial strategies to maximise value for money in place and support wider goals of development and sustainability.		Place Committees	
ICB 11	Agree arrangements for planning responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.	✓		
Partnership Working				
ICB 3	Agree joint working arrangements with partners across West Yorkshire that embed collaboration as the basis for delivery within the ICB plan.	✓		
ICB 3	Develop joint working arrangements with partners in place that embed collaboration as the basis for delivery within the ICB and place plan.		Place Committees	
Constitution	Approve arrangements for coordinating the commissioning of services with other ICBs or with local authorities, where appropriate.	✓		
Constitution	Approve arrangements for risk sharing and /or risk pooling with other organisations (for example arrangements for pooled funds with other ICBs or pooled budget arrangements under section 75 of the NHS Act 2006)[9]	✓ (Joint Committee for S75 arrangements)		
Constitution	Develop arrangements for risk sharing and /or risk pooling with other organisations (for example pooled budget arrangements		Place Committees	

[9] *Need to clarify approval of s75 arrangements – national guidance anticipated.*

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
	under section 75 of the NHS Act 2006), for approval by the ICB Board[10]		(Joint Committee for S75 arrangements)	
Employment and remuneration				
Constitution Section 8	Have oversight of the ICB's responsibilities as an employer including adopting a Code of Conduct for staff	✓		
Constitution 8.6	Approve the terms and conditions, remuneration and travelling or other allowances for Board members, including pensions and gratuities.		Remuneration and Nomination Committee	
Constitution 8.6	Approve the terms and conditions, remuneration and travelling or other allowances for employees of the ICB and to other persons providing services to the ICB.		Remuneration and Nomination Committee	
Constitution 8.6	Approve human resources policies for ICB employees and for other persons working on behalf of the ICB.		Remuneration and Nomination Committee	
	Approve arrangements for staff appointments			Chief Executive (WY) Place Lead (Place)
Operational Business and Risk Management				
	Approve a comprehensive system of internal control that underpins the effective, efficient and economic operation of the ICB.	✓		
	Approve ICB operational policies (excluding those defined as HR, clinical or finance)	✓		
	Approve ICB financial policies		Finance, Investment and Performance Committee	
	Approve ICB clinical policies and clinical pathways		Transformation Committee	

[10] *As above.*

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
Constitution 1.4.5 1.4.7	Approve system-level arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.		System Quality Committee	
	Approve the ICB's arrangements for business continuity and emergency planning.	✓		
Constitution 6	Approve arrangements for managing conflicts of interest and for standards of business conduct.	✓		
	Approve ICB risk management arrangements	✓		
	Make arrangements to implement in place ICB risk management arrangements.		Place Committees	
7.2.4	Agree the ICB's arrangements for handling complaints.	✓		
Constitution 7.2.5	Agree the ICB's arrangements for dealing with Freedom of Information requests.	✓		
Constitution 7	Approve arrangements for complying with the NHS Provider Selection Regime.	✓		
Constitution 7	Agree implementation in place of the arrangements for complying with the NHS Provider Selection Regime.		Place Committees	
Tenders and contracts				
	Approve tenders and contracts.			As per thresholds set out in the Financial Scheme of Delegation.

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
Audit				
Constitution 4.6.7.1	Report and provide assurance to the Board on the effectiveness of ICB governance arrangements.		Audit Committee	
Constitution 4.6.7.1	Receive the annual governance letter from the External Auditor and advise the Board of proposed action		Audit Committee	
Constitution 4.6.7.1	Approve the internal audit, external audit and counter-fraud plans and any changes to the provision or delivery of related services.		Audit Committee	
Constitution 4.6.7.1	Approve the appointment (and where necessary change or removal) of the internal audit provider.		Audit Committee	

West Yorkshire Integrated Care Board
functions and decisions map

Annex 5

West Yorkshire Health and Care Partnership

West Yorkshire Integrated Care Partnership(ICP)

- agrees West Yorkshire Integrated Care Strategy - built from Place health and wellbeing strategies

Strategy

Health and Wellbeing Boards- Bradford District and Craven, Calderdale, Kirklees, Leeds, Wakefield

- agree health and wellbeing strategy for each Place

Strategy

Strategy

West Yorkshire Integrated Care Board(ICB)

- annual plan to deliver the ICP strategy
- arranges for the provision of health services which meet the three tests for working at scale across West Yorkshire:
  1. achieving the safest services and best outcomes for people
  2. reduce variation and sharing learning
  3. solving complex, difficult problems
- statutory functions which cannot be delegated to Place e.g. annual ICB financial plan, system quality assurance, ICB annual report and accounts, audit, terms and conditions of staff, changes to the ICB constitution
- agrees West Yorkshire system plans e.g. workforce, data and digital

Delivery

Delegation

Accountability

Place-based committees of the ICB

- annual plan to deliver the health and wellbeing and ICP strategies
- arranges for the provision of health services in Place
- deployment and management of Place financial allocation
- assuring and improving the quality of services in Place
- deployment and management of Place-based ICB staff
- agreeing place plans e.g. workforce, data and digital

Delegation

Assurance

ICB Committees

- provide the ICB Board with assurance about specific ICB functions e.g. audit, remuneration, quality, finance

Delegation

Assurance

ICB Place Sub Committees

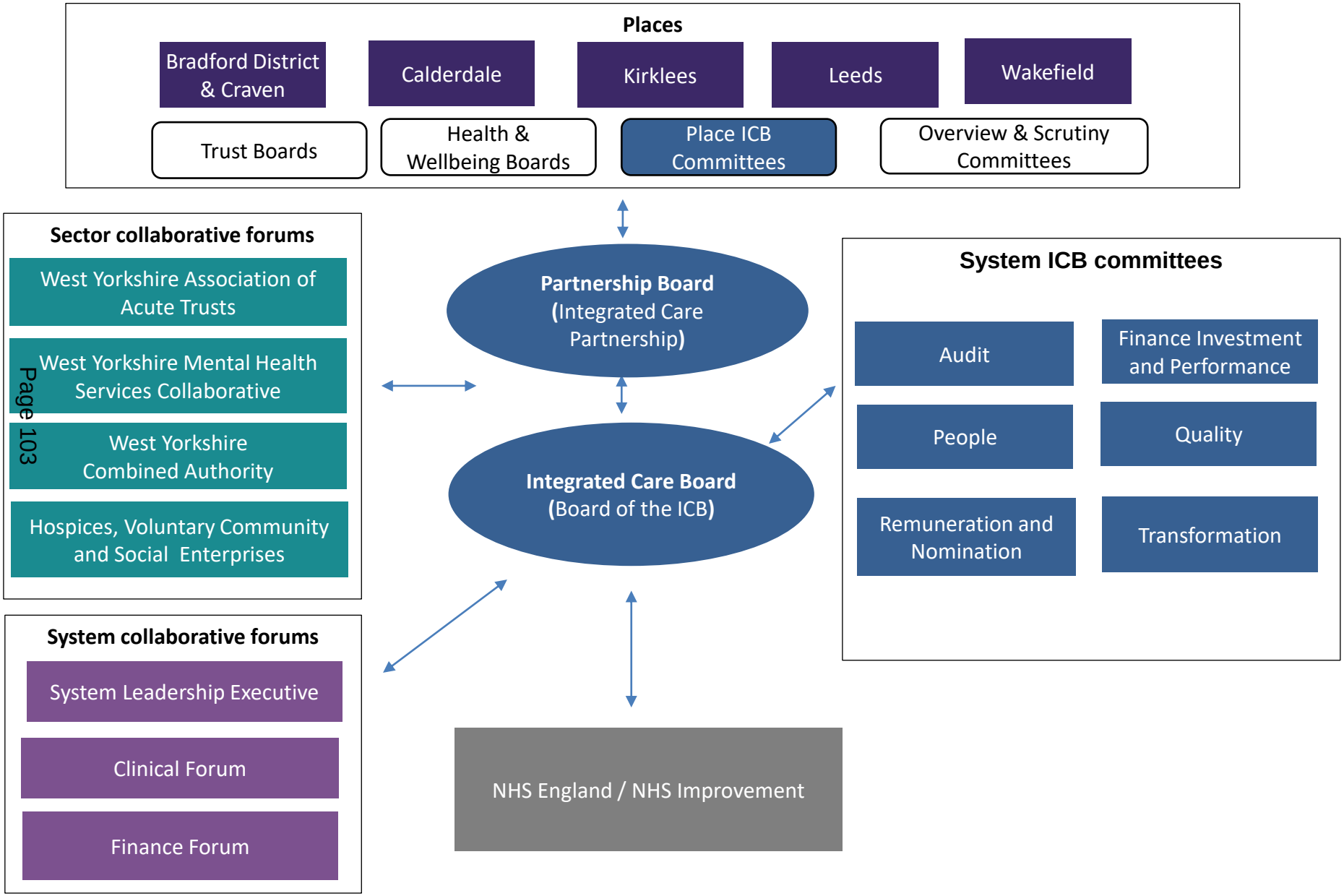
- provide the Place-based Committee with assurance about Place delegated functions e.g. quality, finance

Strategy and delivery supported and informed by collaborative forums

- provider collaboratives e.g. West Yorkshire Association of Acute Trusts, Mental Health, Learning Disability and Autism Alliance
- partnership forums e.g. System Leadership Executive, Clinical Forum

West Yorkshire Integrated Care System - Governance and accountability

Annex 6



West Yorkshire Health and Care Partnership DRAFT ICS Governance standards

(Applicable to: the ICP and ICB, Joint committees and committees with delegated authority from the ICB.)

Principles	Standards
Outcome-focus Our arrangements focus on reducing health inequalities, better health and wellbeing, better quality of care and efficient use of resources.	• Agenda items set out how they contribute to the delivery of the outcomes in Health and Wellbeing strategy/ICB plan/ICP integrated care strategy. • Where relevant, papers are supported by quality and equality impact assessments. • Annual report focuses on delivery of outcomes.
Values Our arrangements reflect our values and ways of working - equal partnership, subsidiarity, collaboration, mutual accountability.	• The agreed principles, values and behaviours of the ICS are set out in the Terms of Reference
Involving citizens and stakeholders We have an inclusive approach, involving citizens and partners from across the system. We are committed to improving diversity in leadership and decision-making.	• Citizens are involved in all relevant decisions. • Decision making involves partners from across our system, including statutory and non-statutory partners.
Transparency We are committed to transparency. We make our decisions in public and publish key policies and registers.	• Decision-taking meetings held in public (unless not in the public interest). • Agenda papers are published at least 5 working days before each meeting. • Key documents are published e.g. minutes, register of procurement decisions.
Probity and independent challenge Our decisions meet high standards of probity and are subject to robust independent challenge.	• Decision-making groups include members independent of any statutory partner. • ICB policy for managing conflicts of interest adopted and implemented.
Accountability and assurance Our arrangements support clear accountability.	• Accountability set out in scheme of delegation or delegation agreement. • Terms of reference agreed and reviewed annually. • Minutes reported in line with agreed reporting mechanisms • Annual report and annual review of performance.

Report author: Angela Brogden

Tel: 0113 3788661

Work Schedule

Date: 26th April 2022

Report of: Head of Democratic Services

Report to: Scrutiny Board (Adults, Health and Active Lifestyles)

Will the decision be open for call in? ☐ Yes ☒ No

Does the report contain confidential or exempt information? ☐ Yes ☒ No

What is this report about?

Including how it contributes to the city's and council's ambitions

- All Scrutiny Boards are required to determine and manage their own work schedule for the municipal year. In doing so, the work schedule should not be considered a fixed and rigid schedule, it should be recognised as a document that can be adapted and changed to reflect any new and emerging issues throughout the year; and also reflect any timetable issues that might occur from time to time.

- The Scrutiny Board Procedure Rules also state that, where appropriate, all terms of reference for work undertaken by Scrutiny Boards will include ' to review how and to what effect consideration has been given to the impact of a service or policy on all equality areas, as set out in the Council's Equality and Diversity Scheme'.

- As well as considering the latest iteration of the Board's work schedule for the remainder of this municipal year, Members are also requested to consider and discuss the draft work schedule of the successor Scrutiny Board for the 2022/23 municipal year.

Recommendations

Members are requested to consider and discuss the Scrutiny Board's work schedule (as presented at Appendix 1) and also the draft work schedule of the successor Scrutiny Board for the 2022/23 municipal year (as presented at Appendix 3).

Why is the proposal being put forward?

1. All Scrutiny Boards are required to determine and manage their own work schedule for the municipal year and therefore the latest iteration of the Board's work schedule for the remainder of the municipal year is attached as Appendix 1 for Members' consideration.

2. The latest Executive Board minutes from the meeting held on 16th March 2022 are also attached as Appendix 2. The Scrutiny Board is asked to consider and note the Executive Board minutes, insofar as they relate to the remit of the Scrutiny Board; and consider any matter where specific scrutiny activity may also be warranted.

Developing the work schedule

3. When considering any developments and/or modifications to the work schedule, effort should be undertaken to:

- Avoid unnecessary duplication by having a full appreciation of any existing forums already having oversight of, or monitoring a particular issue.
- Ensure any Scrutiny undertaken has clarity and focus of purpose and will add value and can be delivered within an agreed time frame.
- Avoid pure "information items" except where that information is being received as part of a policy/scrutiny review.
- Seek advice about available resources and relevant timings, taking into consideration the workload across the Scrutiny Boards and the type of Scrutiny taking place.
- Build in sufficient flexibility to enable the consideration of urgent matters that may arise during the year.

4. In addition, in order to deliver the work schedule, the Board may need to take a flexible approach and undertake activities outside the formal schedule of meetings – such as working groups and site visits, where necessary and appropriate. This flexible approach may also require additional formal meetings of the Scrutiny Board.

Developments since the previous Scrutiny Board meeting

Publication of the final report of the independent review (known as the Ockenden Review) of maternity services at the Shrewsbury and Telford Hospital NHS Trust.

5. The Ockenden Review into the Shrewsbury and Telford Hospital NHS Trust maternity services spans the period from 2000 to 2019 and was commissioned by the then Secretary of State for Health Jeremy Hunt MP at the end of 2016. Donna Ockenden was asked to lead the review, then comprising of 23 families, in the summer of 2017.

6. This final report was published on 30th March 2022 and follows on from the first report, which was published in December 2020. It builds upon the first report, emphasising the importance of progressing the identified local actions for learning (LAfL) and immediate and essential actions (IEAs) to be implemented at the trust and across the wider maternity system in England. However, it also identifies a number of new themes to be shared across all maternity services in England as a matter of urgency to bring about positive and essential change.

7. In March 2021, the Adults, Health and Active Lifestyles Scrutiny Board had received a report on women's health in Leeds, which included a focus on maternal health and referenced the work being undertaken by the Maternity Strategy Programme Board to refresh the Leeds Maternity Strategy based around five key priorities (Preparation for parenthood; Personalised care; Perinatal mental health; The maternity reconfiguration; and Reducing health inequalities).

8. During this same meeting, the Board had also considered a report on the Leeds Fertility IVF service which included proposals to explore and test the market for opportunities to grow and sustain the service in light of a changing competitive market in Leeds.

9. The Chair therefore feels it would appropriate and timely to recommend that the successor Scrutiny Board utilises its July 2022 meeting to receive a report on maternal health provision in Leeds to include an update on the Leeds Maternity Strategy work; the current position of the Leeds Fertility IVF service; the implications of the Ockenden Review findings and how any recommendations are being taken forward across the local maternity system in Leeds.

Developing the work programme for the new municipal

10. Scrutiny Boards are subject to an annual review and appointment process as part of the overall governance arrangements presented and agreed by Council at its annual meeting each year.

11. As such, Scrutiny Boards have tended to adopt different approaches to planning for the new municipal year and providing a 'handover' of issues to be considered by the appropriate and newly constituted Scrutiny Board. Linked to this, a draft schedule of planned meeting dates for the 2022/23 municipal year has been provided (see Appendix 3). This draft work schedule also includes known items of scrutiny activity, such as performance and budget monitoring, as well as other identified areas of work that the Board has already recommended for the successor Scrutiny Board to pursue in the new municipal year.

12. In agreeing to recommend any specific matters for consideration by the successor Scrutiny Board, members should recognise the future work schedule will:
    - Become the responsibility of a successor Scrutiny Board (subject to the arrangements agreed by Council in May 2022).
    - Remain flexible and adaptable to reflect any new and emerging issues or changing priorities identified in the new municipal year.
    - Need to reflect any timetabling issues that might occur from time to time.

13. Nonetheless, setting out proposed meeting dates and a draft work schedule for the new municipal year will provide a foundation that will not only help with the initial planning for next year's Scrutiny Board, it also has the potential to help with planning the work programme in the longer-term.

What impact will this proposal have?

Wards affected: All		
Have ward members been consulted?	☐ Yes	☐No

14. All Scrutiny Boards are required to determine and manage their own work schedule for the municipal year.

What consultation and engagement has taken place?

15. The Vision for Scrutiny also states that Scrutiny Boards should seek the advice of the Scrutiny officer, the relevant Director and Executive Member about available resources prior to agreeing items of work.

What are the resource implications?

16. Experience has shown that the Scrutiny process is more effective and adds greater value if the Board seeks to minimise the number of substantial inquiries running at one time and focus its resources on one key issue at a time.

17. The Vision for Scrutiny, agreed by full Council also recognises that like all other Council functions, resources to support the Scrutiny function are under considerable pressure and that requests from Scrutiny Boards cannot always be met.

18. Consequently, when establishing their work programmes Scrutiny Boards should:

    - Seek the advice of the Scrutiny officer, the relevant Director and Executive Member about available resources;

    - Avoid duplication by having a full appreciation of any existing forums already having oversight of, or monitoring a particular issue;

    - Ensure any Scrutiny undertaken has clarity and focus of purpose and will add value and can be delivered within an agreed time frame.

What are the legal implications?

19. This report has no specific legal implications.

What are the key risks and how are they being managed?

20. There are no risk management implications relevant to this report.

Does this proposal support the council's three Key Pillars?

☒ Inclusive Growth ☒ Health and Wellbeing ☒ Climate Emergency

21. The terms of reference of the Scrutiny Boards promote a strategic and outward looking Scrutiny function that focuses on the best council objectives.

Appendices

22. Appendix 1 – Latest work schedule of the Adults, Health and Active Lifestyles Scrutiny Board for the 2021/22 municipal year.

23. Appendix 2 – Draft minutes of the Executive Board meeting held on 16th March 2022.

24. Appendix 3 – Draft work schedule of the Adults, Health and Active Lifestyles Scrutiny Board for the 2022/23 municipal year.

Background papers

25. None.

SCRUTINY BOARD (ADULTS, HEALTH AND ACTIVE LIFESTYLES)
Work Schedule for 2021/2022 Municipal Year

June 2021	July 2021	August 2021
Meeting Agenda for 15/06/21 at 1.30 pm. ** Consultative Meeting** Scrutiny Board Terms of Reference and Sources of Work (DB) Performance Update (PM)	**Meeting Agenda for 09/07/21 at 10.30 am.** Board Member appointments and the Health Service Developments Working Group arrangement (PDS) **Meeting Agenda for 27/07/21 at 1.30 pm.** ** Consultative Meeting** The Health and Care Bill and the development of the local Integrated Care System (DB)	**No Scrutiny Board meeting scheduled**
Working Group Meetings		
Site Visits / Other		

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response

SCRUTINY BOARD (ADULTS, HEALTH AND ACTIVE LIFESTYLES)
Work Schedule for 2021/2022 Municipal Year

September 2021	October 2021	November 2021
Meeting Agenda for 07/09/21 at 1.30 pm.	**Meeting Agenda for 05/10/21 at 1.30 pm.**	**Meeting Agenda for 16/11/21 at 1.30 pm.**
** Consultative Meeting** Improving 'same day response' services in Leeds (PSR) Restart & Prioritisation Plans for the Delivery of the NHS Health Check Programme (PSR) Update on the development of the local Integrated Care System (PSR)	The development and future vision of stroke services in Leeds, including reference to the adult inpatient rehabilitation service (PSR) Community neurological rehabilitation service redesign (PDS) Understanding and addressing the symptoms of 'long Covid' (PSR)	Update on the development of the local Integrated Care System (PSR) Understanding the impact of Covid-19 and the ongoing recovery measures across the local health and care system (PSR)
Working Group Meetings		
Site Visits / Other		

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response

SCRUTINY BOARD (ADULTS, HEALTH AND ACTIVE LIFESTYLES)
Work Schedule for 2021/2022 Municipal Year

December 2021	January 2022	February 2022
No Scrutiny Board meeting scheduled	**Meeting Agenda for 11/01/022 at 1.30 pm.**	**Meeting Agenda for 08/02/22 at 1.30 pm.**
	Performance report (PM) Financial Health Monitoring (PSR) 2022/23 Initial Budget Proposals (PDS) Best City Ambition – Initial Proposals (PDS) Development of the local Integrated Care System – Draft Constitution of the West Yorkshire Integrated Care Board (PDS) Tackling health inequalities and the Leeds response to the 'Build Back Fairer: Covid 19 Marmot Review – Including proposal for Leeds to become a Marmot City (PDS)	** Consultative Meeting** LTHT update on the impact and response to the Covid-19 Omicron variant (PSR) Primary Care Workforce Development (PSR) Active Leeds and Physical Activity Ambition Update (PSR)
Working Group Meetings		
2022/23 Initial Budget Proposals (PDS) – 9/12/21 @ 3pm.		Access to local NHS dental services (PSR) – 25/02/22 @ 11.30 am
Site Visits / Other		

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response

SCRUTINY BOARD (ADULTS, HEALTH AND ACTIVE LIFESTYLES)
Work Schedule for 2021/2022 Municipal Year

March 2022	April 2022	May 2022
Meeting Agenda for 15/03/22 at 1.30 pm.	**Meeting Agenda for 26/04/22 at 11.30 am**	**No Scrutiny Board meeting scheduled**
Leeds Safeguarding Adults Board Progress Report (PSR) Better Lives Strategy 2022 to 2027 Update Report (PDS) Access to local NHS dental services – working group summary note (PSR)	** Consultative Meeting** Update on the development of the local Integrated Care System (PSR)	
Working Group Meetings		
Site Visits/Other		
		Visits to Active Leeds facilities.

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response

EXECUTIVE BOARD

WEDNESDAY, 16TH MARCH, 2022

PRESENT: Councillor J Lewis in the Chair

Councillors A Carter, D Coupar, S Golton, M Harland, H Hayden, J Pryor, M Rafique and F Venner

APOLOGIES: Councillor S Arif

122 Exempt Information - Possible Exclusion of the Press and Public
There was no information contained within the agenda which was designated as being exempt from publication.

123 Late Items
Supplementary Information – Agenda Item 6 – Energy Costs and Purchasing Strategy
With the agreement of the Chair, prior to the meeting Board Members had been provided with supplementary information in the form of an addendum to this report, which provided updated information with regard to energy purchasing for Members' consideration. (Minute No. 126 refers).

124 Declaration of Interests
There were no interests declared at the meeting.

125 Minutes
RESOLVED – That the minutes of the previous meeting held on 9th February 2022 be approved as a correct record.

INFRASTRUCTURE AND CLIMATE

126 Energy Costs and Purchasing Strategy
Further to Minute No. 118, 9th February 2022, the Director of Resources submitted a report setting out the current and future financial implications for the Council in terms of energy usage, to illustrate the potential future risks of different scenarios, and which sought approval of proposed amendments to the Council's existing energy purchasing strategy in order to manage such risks most effectively.

Prior to the meeting, with the agreement of the Chair, Board Members were in receipt of supplementary information in the form of an addendum to this report, which provided updated information with regard to energy purchasing for Members' consideration.

In introducing the report, the Executive Member for Infrastructure and Climate highlighted the aims of the submitted report which were to take actions in order to help manage the current risks associated with energy costs and

purchasing. The Executive Member also provided the Board with a summary of the work being undertaken in a number of related areas including the decarbonisation agenda, the tackling of fuel poverty and the initiatives which aimed to reduce energy costs for the Local Authority.

Responding to a Member's enquiries on a number of issues, the Board received further information, as illustrated in the addendum, regarding the proportion of energy that was being purchased in advance by the Council over the coming years, with it being noted that the aim was to strike the correct balance in order to spread the risk created by the current volatile market. Also in response to an enquiry, the Board noted that energy was purchased for the Council as a whole, and therefore there was no risk in terms of an uncoordinated approach being taken across the Authority.

With regard to a Member's comments around the Council's approach towards developing greater resilience in this area and as part of that, the actions being taken by the Authority to generate its own energy, the Board noted several areas where work was being progressed which included investment being made to reduce reliance on energy usage, the development of energy generation schemes within the city and also investment in renewables external to the Council.

It was noted that dialogue on the issue of energy costs and the potential implications it could have across the sector had begun at a national level and would continue. It was undertaken that Members would be kept informed of progress made in this area.

RESOLVED –

(a) That the contents of the submitted report (including the supplementary information provided in the form of an addendum presenting updated information with regard to energy purchasing), together with the budget pressures and risks resulting from the recent significant increases in global energy prices, be noted;

(b) That the proposals for a rolling four year forward purchasing strategy for gas and electricity, guided by external market advice, based on the following approach, be approved:-

- 85% of the Council's requirements to be purchased in advance;
- up to 65% of the Council's requirements to be secured through longer-term trades (i.e. between 24 to 48 months in advance of when the energy is required);
- observing the principles, as set out in paragraph 31 of the submitted report.

LEADER'S PORTFOLIO

127 Update on Coronavirus (Covid-19) Pandemic - Response and Recovery Plan

The Chief Executive submitted a report which outlined both the local and national Covid-19 position, including details of the ongoing recovery activity

across the multi-agency partnership, the work that continued in response to the evolving situation in the city, which included proposals to update the Leeds Covid-19 Response and Recovery Plan.

In introducing the report, the Leader noted that it had been two years since the first Covid update report had been submitted to the Board. In addition, he took the opportunity to highlight that all those from across the city who had died as a result of Covid throughout that time remained in the Board's thoughts.

Members received a brief overview of the key themes within the report, with it being noted that the intention was to bring a further update report in the Autumn of 2022, in order to set out plans for the forthcoming winter.

In response to a Member's enquiry, the Board received further information regarding the plans in place for the return of staff back into the office or their usual workplace. It was noted that, in acknowledging the changes that had occurred over the past 2 years, a period of consultation and review was ongoing which would be used to inform how staff would work moving forward. It was highlighted that the updated approach was scheduled to be implemented from June onwards and was likely to include an element of hybrid working for most. Emphasis was placed upon the importance of taking staff along with the Council as part of that transition.

In addition, the benefits of face to face working were highlighted, with officers acknowledging the request of a Member - that particular consideration be given to the support that younger, or less experienced colleagues required in order to assist with their career development.

Responding to a Member's comments regarding service provision, assurance was provided that the effectiveness of Council services should not be compromised by the ways in which staff were working, and where services needed to be delivered in person to run effectively, then those services should now be doing so.

RESOLVED –

(a) That the updates made to the Leeds Covid-19 Response and Recovery Plan, as presented at Annex A to the submitted report, be noted, which details ongoing recovery, response, service pressures and wider risks as the Council plans for the remainder of 2022;

(b) That Annex B to the submitted report, which details the latest Covid-19 Dashboard providing information across the seven themes, be noted, together with Annex C: the updated Leeds Local Outbreak Management Plan, and Annex D: the summary of changes to restrictions announced by the Government, as part of living with Covid-19 safely;

(c) That it be noted that the next Covid-19 report is planned for September 2022, unless there are significant local or national changes, with it also

being noted that the September report will outline the latest position and plans for winter 2022/2023.

RESOURCES

128 Financial Health Monitoring 2021/22 – January 2022 (Month 10)

The Chief Officer (Financial Services) submitted a report presenting the current position on the financial health of the Authority in respect of both the General Fund revenue budget and the Housing Revenue Account, as at month 10 of the current 2021-22 financial year.

In presenting the report the Executive Member for Resources highlighted the key themes. Specifically, it was noted that for 2021/22 the Authority was forecasting a balanced position, as at the end of January 2022 (month 10 of the financial year). In addition, Members' attention was drawn to the lower than expected collection rates for Council Tax and Business Rates, with it being noted that this was a matter that continued to be monitored.

Responding to a Member's comments regarding the potential impact of energy costs upon the Authority's financial position moving forward and the reporting mechanisms that would enable Board Members to be kept informed of developments in this area, assurance was provided that the Board would receive regular updates on such matters, as appropriate. As part of this discussion, the Board also received further information on the levels of energy which had been purchased in advance by the Council for use over the coming months.

In response to a Member's enquiry, the Board received an update on the progress being made to meet the targets within the Children and Families directorate budget action plan, as detailed at Appendix 2 to the submitted report, with it being noted that progress continued to be made by the directorate in this area. Specifically, it was noted that as part of the actions being taken, dialogue continued with health partners regarding contributions towards placements and similarly, discussions continued with other Local Authorities in relation to the potential income that could be brought into the Council as part of the Strengthening Families programme.

RESOLVED –

(a) That the projected financial position of the Authority, as at the end of January 2022 (Month 10 of the financial year), together with the projected impact of COVID-19 on that position, as detailed within the submitted report, be noted;

(b) That for 2021/22, it be noted that the Authority is forecasting a balanced position, as at the end of January 2022.

COMMUNITIES

129 Tackling Inequality and Disadvantage in Communities: Locality Working

The Director of Communities, Housing and Environment submitted a report which provided an update on the work that has taken place to date on the city's new Locality Working approach and which presented and sought the Board's support for the next stages of the approach's development, which included the proposal to expand the Locality Working approach to increase the priority neighbourhood footprint in Leeds' most disadvantaged communities to cover all the 12 (1%) most disadvantaged neighbourhoods.

In presenting the report the Executive Member for Communities highlighted the involvement of the Environment, Housing and Communities Scrutiny Board in the development of the proposed approach, and also that of Community Committee Chairs. In addition, an overview of some of the key actions taken in communities over recent years was provided and the Executive Member extended her thanks to all those who had been involved in the development of this locality working approach to date. In conclusion, the Executive Member highlighted the desire to continue to engage with Elected Members as part of this approach, including through Community Communities and Scrutiny Boards.

Responding to Members' enquiries regarding the methods of evaluating the success and effectiveness of the approach and the allocation of resources for its delivery, the Board received further detail on such matters.

With regard to the approach proposed to be taken in those communities outside of the priority neighbourhoods, Members received an overview of the evolving approach proposed to be taken in those areas and each community across the city, with the aim of prioritising and addressing the bespoke needs which existed in each locality. Specific examples included the development of the role of Community Committees and Community Committee 'Champions', further embedding collaborative relationships with partner organisations and also via the development of Local Area Delivery Plans. Further detail was also provided on the role of the Neighbourhood Improvement Board as part of the strategic approach being taken.

RESOLVED –

(a) That the continued development of the Locality working approach, be supported, and that the evolving whole city approach towards Locality Working around the more targeted, seasonal and responsive approach, be endorsed;

(b) That the upscale of the Locality Working approach to increase the priority neighbourhood footprint in Leeds' most disadvantaged communities to cover all the 12 (1%) most disadvantaged neighbourhoods, be supported; with support also being provided for retaining a focus at the Ward level in the city's 6 priority Wards to enable greater impact and outcomes, through a collective focus to

tackle inequality and poverty and build more thriving and resilient communities;

(c) That work with Elected Members and Community Committees to explore how the role and responsibilities of Community Committees could be even further enhanced through the new Locality Working approach, be supported.

ENVIRONMENT AND HOUSING

130 Capital Housing Investment Programme Update

The Director of Communities, Housing and Environment submitted a report providing an update on the improvement work which had been undertaken and which was planned for delivery to improve the quality of Council housing stock across the city.

In presenting the report, the Executive Member for Environment and Housing provided an overview of the key investment activity which had been undertaken in the Council Housing stock across the city and the criteria which was used to deliver such investment.

Responding to a Member's enquiry regarding potential charges incurred by leaseholders of properties in high rise buildings as a result of improvement works undertaken, the Board received further detail in relation to this, with officers undertaking to provide the Member in question with a further breakdown of the information requested.

Also in response to a Member's specific enquiry, the Board received an update on a proposed scheme which was being developed regarding investment in a number of system built properties.

RESOLVED –

(a) That the contents of the submitted report, including the investment activity underway to improve the quality of council housing across the city, be noted;

(b) That the forward programme of investment, which will be implemented by the Head of Strategy and Investment, and which will continue decarbonising the Council housing portfolio and improving the quality of homes in Council ownership, be supported.

ECONOMY, CULTURE AND EDUCATION

131 Outcome of the Consultation on a Proposal to Decommission the Resource Provision at Gledhow Primary School

The Director of Children and Families submitted a report presenting the outcomes from the consultation undertaken on a proposal to decommission the Speech and Language Resource Provision at Gledhow Primary School with effect from August 2022. The report summarised the consultation responses received and sought approval for the publication of a statutory

notice on a proposal to decommission the Resourced Provision from August 2022.

RESOLVED –

(a) That having noted the outcome of the informal consultation undertaken, the publication of a statutory notice on a proposal to decommission the Resourced Provision at Gledhow Primary School from August 2022, be approved;

(b) That it be noted that the responsible officer for the implementation of such matters is the Head of Learning Inclusion.

132 Future Talent Leeds

The Director of City Development submitted a report which presented details of the work undertaken to date to develop a new Talent Plan for Leeds and which sought approval of the proposed Future Talent Plan and delivery approach, including the vision and overarching action framework, as detailed at appendix 1 to the submitted report, which set out the high level action areas proposed to be used to shape the specific projects and initiatives of the Council and its partners.

In presenting the report, the Executive Member for Economy, Culture and Education highlighted the key challenges currently being faced in the labour and skills market both locally and nationally and provided an overview of how the proposed plan looked to address such challenges.

Responding to a Member's enquiry, the Board received further detail on the processes which would be used to evaluate the effectiveness of the proposed plan. Information was specifically provided on how outcomes were currently measured in terms of those initiatives delivered by the Council, where Council resource or Council obtained grants were being utilised by partner organisations and via the continued use of data sources in the field of employment and skills. Members also noted the progress being made towards the adoption of the Social Progress Index, which it was noted would be a further source of relevant data.

Also in response to a Member's enquiry, the Board received further detail on the initiatives in place to support existing members of the workforce who were seeking employment or a change in career, with a specific example being provided on initiatives in place to support that cohort in entering expanding industries in Leeds such as the digital sector.

RESOLVED –

(a) That the Future Talent Plan and delivery approach, be approved, with the plan being developed online and launched in May 2022;

(b) That the responsibility for the implementation of the Future Talent Plan be delegated to the Director of City Development, with the exception of any projects or initiatives identified that sit under the delegated

authority of the Director of Resources which will be their responsibility to implement;

(c) That it be noted that responsibility for any projects or initiatives included in the plan which are to be delivered by the Council's partners in the city will remain with them.

133 Leeds Museums & Galleries Strategy 2022-27

The Director of City Development submitted a report presenting for the Board's consideration and approval the proposed new Leeds Museums and Galleries Strategy entitled, '*Deepening Connections, Widening Impact*', for the period 2022-2027.

In presenting the report, the Executive Member for Economy, Culture and Education highlighted that the proposed strategy was made up of six key outcomes, with six objectives per outcome. In addition, the Executive Member provided an overview of the key aspects of the Leeds museums and galleries estate, which was spread across nine venues.

Members welcomed the proposals detailed within the submitted report.

RESOLVED – That the new Leeds Museums and Galleries Strategy, as detailed at appendix 1 to the submitted report, be approved, and that responsibility for the implementation of the strategy be delegated to the Head of Service, Leeds Museums and Galleries via the Director of City Development, from March 2022.

DATE OF PUBLICATION: FRIDAY, 18TH MARCH 2022

LAST DATE FOR CALL IN OF ELIGIBLE DECISIONS: 5.00 P.M., FRIDAY, 25TH MARCH 2022

SCRUTINY BOARD (ADULTS, HEALTH AND ACTIVE LIFESTYLES)
Work Schedule for 2022/2023 Municipal Year

June 2022	July 2022	August 2022
Meeting Agenda for 21/06/22 at 1.30 pm.	**Meeting Agenda for 19/07/22 at 1.30 pm.**	**No Scrutiny Board meeting scheduled**
Scrutiny Board Terms of Reference and Sources of Work (DB) Performance Update (PM) Update on the local Integrated Care System (PSR)	Provision of non-invasive post-mortems (PSR) Maternal health provision in Leeds (PSR) Review of visiting policies and patient advocacy within local healthcare settings and care homes (PSR)	
Working Group Meetings		
Site Visits / Other		

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response

SCRUTINY BOARD (ADULTS, HEALTH AND ACTIVE LIFESTYLES)
Work Schedule for 2022/2023 Municipal Year

September 2022	October 2022	November 2022
Meeting Agenda for 20/09/22 at 1.30 pm.	**Meeting Agenda for 18/10/22 at 1.30 pm.**	**Meeting Agenda for 22/11/22 at 1.30 pm.**
Arrangements surrounding the implementation of Liberty Protection Safeguards (PDS) Access to local NHS dental services – update (PSR)	Draft system strategy for Leeds Stroke Services (PDS) Community neurological rehabilitation service – update (PSR)	Leeds Safeguarding Adults Board Progress Report (PSR)
Working Group Meetings		
Site Visits / Other		

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response

SCRUTINY BOARD (ADULTS, HEALTH AND ACTIVE LIFESTYLES)
Work Schedule for 2022/2023 Municipal Year

December 2022	January 2023	February 2023
No Scrutiny Board meeting scheduled	**Meeting Agenda for 17/01/023 at 1.30 pm.**	**Meeting Agenda for 21/02/23 at 1.30 pm.**
	Performance report (PM) Financial Health Monitoring (PSR) 2023/24 Initial Budget Proposals (PDS) Best City Ambition – Update (PDS)	Update on the local Integrated Care System (PSR)
Working Group Meetings		
Site Visits / Other		

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
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SCRUTINY BOARD (ADULTS, HEALTH AND ACTIVE LIFESTYLES)
Work Schedule for 2022/2023 Municipal Year

March 2023	April 2023	May 2023
Meeting Agenda for 21/03/23 at 1.30 pm.	**No Scrutiny Board meeting scheduled**	**No Scrutiny Board meeting scheduled**
Working Group Meetings		
Site Visits/Other		

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response