Appendix A

NHS
Leeds
Clinical Commissioning Group

West Yorkshire Integrated Care Board – draft constitution

Background and context

1. The Health and Care Bill establishes **Integrated Care Systems (ICSs).** ICSs will be made up of a statutory NHS body – the **Integrated Care Board (ICB)** and a statutory joint committee - the **Integrated Care Partnership (ICP).** ICBs will be able to **delegate significantly to place level** and to **provider collaboratives**.

2. The ICB will be directly **accountable for NHS spend and performance** within the system. The ICP will be a wider and more inclusive group than the ICB and will develop an **integrated care strategy** to address the health, social care, and public health needs of their system. The membership and detailed functions of the ICP is up to local areas to decide.

3. **Place-based arrangements** between local authorities, the NHS and providers of health and care will be left to local areas to arrange. The statutory ICB will work to support places to integrate services and improve outcomes. **Health and Wellbeing Boards** will continue to have an important role in local places. **NHS provider organisations** will remain separate statutory bodies and retain their current structures and governance but will work collaboratively with partners.

4. Place-based working will remain critical and the West Yorkshire ICS has committed to discharge its duties via place-based partnerships. In effect this means the Leeds Health and Care Partnership which is already established. Though each place in West Yorkshire will be required to have formal governance in place through which the WY ICS duties can be discharged. These include a Committee of the West Yorkshire ICB with appropriate sub-committees covering: system quality and people's experience; system delivery; and system finance. All of these will need to interconnect with and build on existing health and care partnership arrangements at place.

5. A **duty to co-operate will** be introduced to promote collaboration across the healthcare, public health and social care system. ICSs, NHS England and NHS providers will be required to have regard to the '**Triple Aim**' of better health and wellbeing for everyone, better care for all people, and sustainable use of NHS resources.

6. The draft Health and Care Bill reflects how we already work in West Yorkshire. It recognises that collaborative working produces better health and wellbeing outcomes and a more effective approach to reducing health inequalities. The WY Partnership has demonstrated the value of collaboration in our response to COVID-19 and a wide range of other initiatives that are making a positive difference for local people. We believe that the legislation is 'catching up' with how we work and that the establishment of the ICB will help us to further improve the health and wellbeing of people across West Yorkshire.

7. The Bill requires 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 have agreed that the West Yorkshire Health and Care Partnership should **co-ordinate the development of the constitution and involvement with stakeholders**. It is important to note that feedback from stakeholders is sought on the **content of the draft constitution, not about whether ICBs should be established –** as the latter will be required by law.

8. An ICS Governance Working Group, chaired by Tim Ryley, the Accountable Officer for Leeds CCG, has **led the co-production of the ICB constitution**. The Group includes partners from across our places (Bradford District and Craven; Calderdale, Kirklees, Leeds and Wakefield) and our sectors including NHS commissioners, provider collaboratives, local authorities, the voluntary, community AND social enterprise (VCSE) sector, Healthwatch and our Race Equality Network.

The ICB constitution

9. The draft constitution is attached for the Scrutiny Board's consideration. Content which is prescribed by the national model is in black text, with local content in green. The constitution, and any subsequent changes to it, will need to be approved by NHS England. The constitution is a high-level document, designed to give us the flexibility to develop our future arrangements. Much of the detail of our governance arrangements (for example Committee Terms of reference, scheme of delegation, governance policies) will be included in an accompanying Governance Handbook, which we will publish, but will not need to be agreed by NHS England. The key sections of the constitution are set out below.

Section 1 – Introduction

10. This section is based on the Memorandum of Understanding that all Partners agreed in 2018 and which has underpinned our work as a Partnership. We have a mature partnership, in which Health and Wellbeing Boards and the West Yorkshire Partnership Board set strategic direction. We have strong place arrangements, mature provider collaboratives and inclusive and transparent system leadership. The constitution supports our principles of subsidiarity, with key decisions about the majority of ICB functions and resources remaining in our places – Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield.

11. Effective governance is as much about ways of working, values and principles as arrangements and structures. It is critical that our ICB arrangements reflect and support the values and culture that we have established as a genuine partnership. We want to ensure that the ICB supports our focus on outcomes, reducing health inequalities and commitment to diversity and equality. Citizen voice will continue to be at the centre of decision-making.

12. Our Integrated Care Partnership (ICP), which will be chaired by a local authority elected member, will set the overall strategy for our ICS. Our existing Partnership Board already largely fulfils the role of an ICP and means that we are well placed to transition to the new arrangements. In its five year plan the Partnership Board has set out our strategic direction and how we will work together to improve health and wellbeing and reduce health inequalities. The Partnership Board focuses on the connections between health and wider issues including socio-economic development, housing, employment and environment.

13. Our integrated care strategy will be built from the five place-based strategies which in turn will have been signed off by Health and Wellbeing Boards in each place and delivered through place-based partnership arrangements. Provider collaboratives will play a key role at both West Yorkshire and place level in delivering operational support, 'at scale' services and facilitating continuous development between partners.

Section 2 – Composition of the ICB Board

14. Our principles of subsidiarity mean that the ICB will primarily discharge its duties through delegation to place, 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. At system level, the ICB board will have a key role in executing the strategy set by the Integrated Care Partnership; its delivery in place and through provider collaboratives; and through engagement with partners at WY level.

15. Whilst aligning with nationally mandated roles, we propose to use our system language of places and providers, supported by system executive, clinical and professional leadership and overseen by independent lay members. The board is built on principles of inclusivity, independent challenge and citizen voice and reflects the scale and complexity of a diverse system which serves a population of 2.4. million.

16. The board will be one part of a complex, mature and inclusive decision-making framework, ensuring inclusivity, independent challenge and effectiveness across our system. The proposed composition is:

Proposed WY ICB Board	**Minimum national requirement**
Independent Lay perspective • Chair • 3 Lay members	• Chair • 2 Non-Executive directors
Healthwatch perspective • Healthwatch	• No minimum requirement
Place perspective • 5 Place members • Local authority	• No minimum place requirement • 1 local authority member
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
System executive, clinical and professional • Chief Executive • Director of Finance • Director of Nursing • Medical Director • Director of Public Health	• Chief Executive • Director of Finance • Director of Nursing • Medical Director • No Public Health requirement
Total Board: 21	10

17. Other Participants who will inform decision-making include:
    - The Chair of the Integrated Care Partnership
    - Directors of the ICB
    - A representative of the West Yorkshire Race Equality Network
    - Subject matter experts as required
    - Any other person that the Chair considers can contribute to the matter under discussion

Section 3 - Appointments process for the Board

18. This section outlines the proposed nomination and appointment process for all Board roles. The process will include a requirement to have regard to the Partnership's commitment to improve the diversity of its leadership. The minimum eligibility criteria for all roles are to meet the "fit and proper person test", be willing to uphold Nolan Principles and fulfil the requirements for experience, knowledge and skills set out in a role specification. All Board appointments are subject to the approval of the Chair.

Section 4 – Arrangements for the exercise of our functions

19. This section sets out the high-level arrangements for exercising the ICB's functions. The vast majority of ICB capacity and resources will remain in our places. To enable the delegation of key decisions and functions, places are developing governance models and committee structures to fit local circumstances, within the context of the principles set out in our constitution. Further detail about the proposed scope of the delegation is included in the draft high level scheme of delegation **(Annex 1)** and functions and decisions map **(Annex 2**). We propose that arrangements for the scrutiny of ICB plans and decisions should align with our scheme of delegation and reservation, with WY level matters being scrutinised by JHOSC and place matters by the relevant place scrutiny committee.

20. In line with our approach of minimising detail in the constitution, we have not included details of the committees that the ICB may establish, except for the place-based committees to which the ICB will delegate many of its functions and those committees required by statute (Audit and Remuneration). A draft structure diagram is attached at **Annex 3.**

21. We have developed a set of governance standards which summarise the principles set out in our constitution and which we will apply across our system. The standards cover outcomes, values, transparency, citizen involvement, diversity, independent challenge and probity and are attached at **Annex 4.**

Section 5 - Procedures for Making Decisions

22. This section is linked to the Standing Orders attached at Appendix 2 to the constitution.

Section 6 – Conflicts of interest and standards of business conduct

23. This section sets out the principles of our approach to managing conflicts of interest. ICB policies for managing conflicts and standards of business conduct are currently under development.

Section 7 – Accountability and transparency

24. This section sets out our overarching principles for ensuring accountability and transparency. It covers:

    - Arrangements for holding meetings in public and publishing papers.
    - Arrangements for independent challenge, including complying with local authority overview and scrutiny requirements.

25. This section also includes our proposed approach to complying with the provider selection regime. Further details about this will be included in a separate policy.

Section 8 - Terms and conditions of employees

26. This section covers our proposed approach to determining the terms and conditions of employees, including the establishment of a Remuneration and Nomination Committee.

Section 9 - Public involvement

27. This section sets out our principles for involving people and communities and includes a link to the Partnership's communication and involvement framework.

Appendix 2 - Standing orders

28. The standing orders set out our arrangements for making decisions, which are based on governance good practice.

Next steps and timeline

29. The Partnership invites feedback on the content of the draft constitution and the supporting documents. In particular, we would welcome feedback on:

    a) the composition of the Board of the ICB.
    b) the appointments process for members of the Board of the ICB.
    c) the delegation of functions to place-based committees of the ICB, as set out in the high level scheme of reservation and delegation (Annex 2) and functions and decisions map (Annex 3).
    d) the way the ICB will deal with conflicts of interest.
    e) our principles for ensuring accountability and transparency.
    f) how the ICB will comply with the requirements of the NHS Provider Selection Regime (subject to regulations).
    g) the way the ICB intends to involve the public, patients, carers and stakeholders.

30. The timetable for involvement on the constitution is as follows:

Draft constitution published for comment Draft to NHS England.	8th November 2021
Involvement on constitution closes	14th January 2022
Collation of comments about the constitution	Nov to Jan 2022
Draft constitution amended to take account of comments.	Feb 2022
Final draft constitution presented to Partnership Board (3rd March) and Shadow ICB Board (TBA)	March 2022
Final version to NHS England.	11th March 2022
Constitution comes into being with creation of ICB	1st April 2022

Recommendation

31. The Scrutiny Board (Adults, Health and Active Lifestyles) is asked to consider and provide feedback on the draft constitution of the West Yorkshire Integrated Care Board (ICB) as part of the broader consultation process.

1. Introduction

1.1 Background/ Foreword

1.1.1 NHS West Yorkshire Integrated Care Board is part of 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 deliver the strategy set by our Integrated Care Partnership (ICP). 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.

1.1.3 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).

1.1.4 The West Yorkshire Health and Care Partnership ('the Partnership') includes eleven NHS providers[2], 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.

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

1.1.5 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.

1.1.6 The voluntary, community and social enterprise sector (VCSE) is an important part of our Partnership, working across all our places and programmes of work. 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.

1.1.7 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.

1.1.8 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.

1.1.9 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.

1.1.10 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.

1.1.11 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 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.

1.1.12 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.

1.1.13 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 housing, employment, social inclusion and the physical environment.

1.1.14 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

1.1.15 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 through GPs and social care 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.

1.1.16 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.

1.1.17 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.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS West Yorkshire ICB[3] ("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 1989 and section 14Z32 of the 2006 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);

[3] Naming conventions to be confirmed.

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

a) where the ICB applies to NHS England in accordance with NHS England's published procedure 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. 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 selection and appointment processes for 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 / who functions and decisions have been delegated to. (A draft high-level scheme of delegation is attached at Annex 1)

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). (A draft functions and decisions map is attached at Annex 2 and a draft governance structure at Annex 3)

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

d) **The ICS Governance Handbook[4]–** 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 to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
- [Add other key contents].

e) **Key policy documents[5] -** including:
- Standards of Business Conduct Policy
- Conflicts of interest policy and procedures
- Policy for public involvement and engagement

[4] The Governance Handbook will be published separately.

[5] 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 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 or a prescribed description
- the local authorities 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.

2.5 The ICB has five Partner Members.

2.6 As per NHS England Policy, the ICB has appointed the following additional Ordinary Members:

2.6.1.1 three executive members, namely:

- Director of Finance
- Medical Director
- Director of Nursing

2.6.1.2 Three independent non-executive members.

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

a) A member representing Bradford, District and Craven place.

b) A member representing Calderdale place.
c) A member representing Kirklees place.
d) A member representing Leeds place.
e) A member representing Wakefield place.
f) A member representing Directors of Public Health.
g) A member representing Healthwatch.
h) A member representing the Voluntary, Community and Social Enterprise sector.

Regular Participants and Observers at Board Meetings

2.8 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.

2.9 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
- Directors of the ICB
- A representative of the West Yorkshire Race Equality Network
- Subject matter experts as required
- Any other person that the Chair considers can contribute to the matter under discussion.

2.10 Observers 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 not address the meeting and may not vote.

3. Appointments Process for the Board[6]

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 1.1.17.

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 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.

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

3.2.5 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.

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[6] 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.

3.2.6 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;

3.2.7 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.

3.2.8 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).

3.2.9 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.

3.2.10 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.

b) Add any local criteria

3.3.3 In addition to criteria specified in 3.2, 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.

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

b) Specify any further local criteria

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) Specify any further local exclusions

3.5 Partner Members - NHS Trusts and Foundation Trusts

3.5.1 This Partner Member *description to be inserted in accordance with the regulations, (not yet available)*: 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) Specify any other criteria as may be set out in any NHS England guidance
c) One shall bring the perspective of NHS Trusts or FTs providing acute services
d) One shall bring the perspective of NHS Trusts or FTs trusts providing mental health, learning disability and autism services.
e) One shall bring the perspective of NHS Trusts or FTs providing community services.
f) Specify any other criteria agreed locally by the ICB

3.5.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) add any exclusion criteria set out in NHS E guidance
c) Add any locally determined exclusion criteria

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 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 *description to be inserted in accordance with the regulations which are not yet available*].

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

a) Specify any other criteria set out by NHS England's guidance

b) General practitioners who provide 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.

3.6.3 Individuals will not be eligible if:

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

b) Add any criteria set out in NHS E guidance

c) Add any locally determined criteria

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** 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 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 *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 relevant Executive level role of one of the bodies listed at 3.7.1
b) Specify any other criteria set out by NHS England's guidance
c) Be from a local authority at 3.7.1 which has statutory social care responsibility.

3.7.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) [Add any locally determined criteria
c) and any criteria set out in NHS E guidance]

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
c) Specify any other criteria set out by NHS England's guidance
d) Specify any other criteria agreed locally by the ICB

3.8.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Add any locally determined criteria

c) and any criteria set out in NHS E guidance

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 or Midwife
c) Specify any other criteria set out by NHS England's guidance
d) Specify any other criteria agreed locally by the ICB

3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Add any locally determined criteria
c) and any criteria set out in NHS E guidance

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) Specify any other criteria set out by NHS England's guidance

c) 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) [Add any locally determined criteria

c) and any criteria set out in NHS E guidance]

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 Three Independent Non-Executive Members

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

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

a) Will be independent and not hold positions or offices in other health and care organisations within the ICB area.

3.11.3 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

3.11.4 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
e) Specify any other criteria set out by NHS England's guidance
f) Specify any other criteria agreed locally by the ICB

3.11.5 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) add any locally determined criteria
d) and any criteria set out in NHS E guidance

3.11.6 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.

3.11.7 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.

3.11.8 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.

3.11.9 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) add any exclusion criteria set out in NHS E guidance
c) add any locally determined exclusion criteria

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 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) Specify any other criteria set out by NHS England's guidance
c) Specify any local criteria.

3.14.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) [Add any locally determined criteria

c) and any criteria set out in NHS E guidance]

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 - Voluntary, community and social enterprise sector

3.15.1 This Member will bring the perspective of organisations from the voluntary, community and social enterprise sector (VCSE) which provide health and care services in the ICB area.

3.15.2 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 voluntary, community and social enterprise sector which provide health and care services in the ICB area.
b) Specify any other criteria agreed locally by the ICB

3.15.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) add any exclusion criteria set out in NHS E guidance
c) add any locally determined exclusion criteria

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** 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

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 VCSE partner member up to the maximum number of terms permitted for their role.

3.16 Member - Healthwatch

3.16.1 This Member will bring the perspective of all Healthwatch organisations 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:

a) Be a senior leader of a Healthwatch organisation in the ICB area.
b) Specify any other criteria agreed locally by the ICB

3.16.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) add any exclusion criteria set out in NHS E guidance
c) add any locally determined exclusion criteria

3.16.4 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.

3.16.5 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.

3.16.6 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 Healthwatch partner Member up to the maximum number of terms permitted for their role.

3.17 Board Members: Removal from Office.

3.17.1 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.

3.17.2 With the exception of the Chair of the 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

3.17.3 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.

3.17.4 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.

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

3.17.6 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.

3.18 Terms of Appointment of Board Members

3.18.1 With the exception of the Chair, Non-executive members and Chief executive, 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, Non Executives and chief executives will be set by NHS England.

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

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

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.

4.2 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] (Note: a high level SoRD is attached at Annex 1)

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. (Note: A draft functions and decisions map is attached at Annex 2)

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

4.5.3 The map includes:

4.5.3.1 Key functions reserved to the Board of the ICB

4.5.3.2 Commissioning functions delegated to committees and individuals.

4.5.3.3 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;

4.5.3.4 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[7].

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:

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.

[7] Under development.

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

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:

4.6.7.1 **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.

4.6.7.2 **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)[8]

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 specify where

[8] 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 our 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 and committee meetings 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
d) add further documents

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[9] including:

a) evidencing that it has properly exercised the responsibilities conferred on it by the regime by:
   - publishing the intended selection approach in advance.
   - publishing the outcome of decisions made and the details of contracts awarded.

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

- 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.

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

7.4.3 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
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.

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

1.1. 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.

1.2. 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.

1.3. 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.

1.4. 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 meeting 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 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.

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 11 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 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

4.8.1 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

4.8.1.1 To determine locally

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 and Observers (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, including at least one independent non-executive director, in the given circumstances.

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 ICB at which public functions are exercised will 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 If the organisation has a seal, arrangements made for its safe keeping and authorisation of its use should be set out here.

West Yorkshire Integrated Care Board – Illustrative high-level Scheme of Reservation and Delegation (SoRD)
(detailed arrangements will be set out in the SoRD, which will be approved by the ICB Board)

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
Employment and remuneration				
Constitution Section 8	Have oversight of the ICB's responsibilities as an employer including adopting a Code of Conduct for staff	✓		
Rem and Nom ToR	Approve the terms and conditions, remuneration and travelling or other allowances for Board members, including pensions and gratuities.		Rem and Nom Committee	
Rem and Nom ToR	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.		Rem and Nom Committee	
Rem and Nom ToR	Approve human resources policies for ICB employees and for other persons working on behalf of the ICB.		Rem and Nom Committee	
	Approve arrangements for staff appointments			Chief Executive (WY) Place Lead (Place)
Operational Business and Risk Management				
	Approve ICB operational policies (i.e. excluding those defined as clinical or finance)	✓		
Finance ToR	Approve ICB financial policies		Finance Committee	
SQG ToR	Approve ICB clinical policies and clinical pathways		System Quality Group	
SQG ToR	Approve system-level arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.		System Quality Group	
Constitution	Approve arrangements for managing conflicts of interest	✓		

West Yorkshire Integrated Care Board – Illustrative high-level Scheme of Reservation and Delegation (SoRD)
(detailed arrangements will be set out in the SoRD, which will be approved by the ICB Board)

Reference	Decision / Responsibilities	Reserved to the Board	Delegated to Committee or Sub Committee	Delegated to Chair or officer
	Approve ICB risk management arrangements	✓		
	Make arrangements to implement in place ICB risk management arrangements.		Place Committees	
	Agree the ICB's arrangements for handling complaints.	✓		
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	
Audit ToR	Report and provide assurance to the Board on the effectiveness of ICB governance arrangements.		Audit Committee	
Audit ToR	Receive the annual governance letter from the External Auditor and advise the Board of proposed action		Audit Committee	
Audit ToR	Approve the internal audit, external audit and counter-fraud plans and any changes to the provision or delivery of related services (other than the appointment or removal of the external auditor where authority is reserved to the Board).		Audit Committee	
	Functions delegated to other statutory bodies[8]			

[8] Any matters delegated to other statutory bodies will be set out in the detailed SoRD.

Annex 2

West Yorkshire Health and Care Partnership

West Yorkshire Integrated Care Board
functions and decisions map

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

Delegation

Assurance

ICB Committees

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

ICB Place Sub Committees

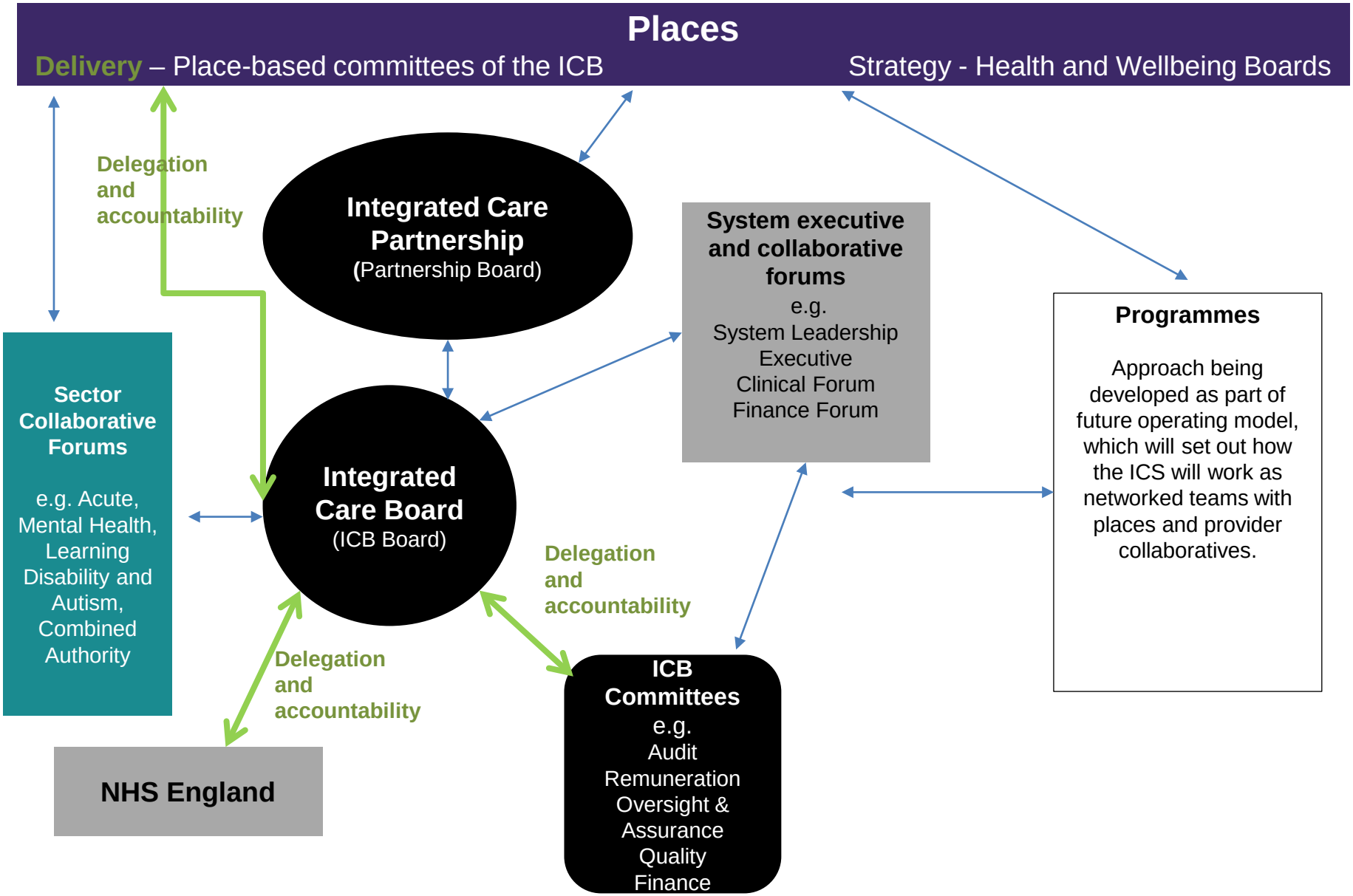
- provide the Place-based Committee with assurance about Place delegated functions e.g. quality, finance

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

Annex 3

Our Integrated Care System - a partnership of places, programmes and sectors



Annex 4

West Yorkshire Health and Care Partnership

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.