



Derby and Derbyshire
Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board

Constitution

Version	Amendment	Effective date
V1.0	ICB Board, 1 July 2022	1 July 2022
V1.1	Amendment to Constitution to reflect changes in Board composition September 2022 Amendment to Section 1.3.3 - Area Covered by the ICB NHSE amendments in line with annex to final guidance on preparing ICB Constitutions updated by legal team.	14 December 2022
V1.4/ 1.5	Amendment to Executive titles Amendment to Section 2.3 Regular Participants and observers at Board Meetings	22 December 2023
V1.6	Amendments to Constitution recommended by NHSE Guidance PAR 1551	4 November 2024
V1.7	Amendment to Section 3.9.1(a), 3.10.1(a), 3.11.1(a), 3.13.1(a)(i) and 3.13.3(a)(i)	27 March 2025
V1.8	Amendments to 3.6.6, 3.7.7 and 3.8.7 to enable the terms of office for Partner Members of the Board to be extended in exceptional circumstances.	3 June 2025
V1.9	Amendment to 3.5.4(b), as directed by NHS England	17 July 2025

CONTENTS

1.	Introduction	5
1.1	Background/Foreword	5
1.2	Name	7
1.3	Area Covered by the Integrated Care Board	7
1.4	Statutory Framework	8
1.5	Status of this Constitution	9
1.6	Variation of this Constitution	9
1.7	Related Documents	10
2.	Composition of The Board of the ICB	11
2.1	Background	11
2.2	Board Membership	12
2.3	Regular Participants and Observers at Board Meetings	14
3.	Appointments Process for the Board	14
3.1	Eligibility Criteria for Board Membership:	14
3.2	Disqualification Criteria for Board Membership	14
3.3	Chair	16
3.4	Deputy Chair and Senior Non-Executive Member roles	17
3.5	Chief Executive	17
3.6	Partner Members – NHS Trusts and Foundation Trusts within the ICB area	17
3.7	Partner Member – Providers of Primary Medical Services	19
3.8	Partner Members – Local Authorities	21
3.9	Chief Medical Officer	22
3.10	Chief Nursing Officer	23
3.11	Chief Finance Officer	23
3.12	Four Non-Executive Members	23
3.13	Other Board Members	24
3.14	Board Members: Removal from Office	26
3.15	Terms of Appointment of Board Members	27

4.	Arrangements for the Exercise of our Functions.....	27
4.1	Good Governance.....	27
4.2	General.....	28
4.3	Authority to Act.....	28
4.4	Scheme of Reservation and Delegation	29
4.5	Functions and Decision Map	29
4.6	Committees and Sub-Committees.....	29
4.7	Delegations made under section 65Z5 of the 2006 Act	31
5.	Procedures for Making Decisions.....	32
5.1	Standing Orders.....	32
5.2	Standing Financial Instructions (SFIs)	32
6.	Arrangements for Conflict of Interest Management and Standards of Business Conduct	32
6.1	Conflicts of Interest	32
6.2	Principles	33
6.3	Declaring and Registering Interests.....	34
6.4	Standards of Business Conduct	35
7.	Arrangements for ensuring Accountability and Transparency.....	35
7.2	Principles	35
7.3	Meetings and publications	36
7.4	Scrutiny and Decision Making	37
7.5	Annual Report	37
8.	Arrangements for Determining the Terms and Conditions of Employees.....	38
9.	Arrangements for Public Involvement.....	39
	Appendix 1 – Standing Orders.....	42
	Appendix 2 – Definitions of Terms Used in this Constitution.....	48
	ICB Model Constitution Supporting Notes.....	50

1. INTRODUCTION

1.1 Background/Foreword¹

1.1.1 NHS Derby and Derbyshire Integrated Care Board (ICB) is the health statutory body for the Derby City and Derbyshire population. The ICB is a new statutory organisation and will take over the duties and responsibilities of the NHS Derby and Derbyshire Clinical Commissioning Group which will be disestablished on 30th June 2022. The ICB will also be responsible for a range of new statutory duties set out in the Act.

1.1.2 ICSs are partnerships of health and care organisations that come together to plan and deliver joined-up services and to improve the health of people who live and work in their area. Each ICS will comprise of an:

- (a) Integrated Care Board bringing the NHS together locally to improve population health and care; and an
- (b) Integrated Care Partnership (ICP): the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS.

1.1.3 NHSE has set out the following as the four core purposes of ICSs:

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

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

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

1.1.4 The Derbyshire ICS will have an NHS Body Integrated Care Board which has a distinct purpose, with governance and leadership arrangements designed to promote greater collaboration across the NHS and with other local partners. Adapting to this requires a significant change in the way commissioning activities are delivered and functions are carried out to understand population needs, plan

services and allocate resources, which address the Derby City and Derbyshire population's health outcomes and secure the provision of services collaboratively with partners.

1.1.5 The Derbyshire ICS will also have an ICP at system level, established as equal partner members. The ICP will operate as the forum to bring partners e.g. local government, NHS and others, together across the Derbyshire ICS area to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for the population of Derby City and Derbyshire. For a number of years there have been local collaborative arrangements at the 'neighbourhood' level. These have involved a coalition of commissioners, NHS Trust providers, local authorities, primary care, the voluntary and community sector, and the public working together to better meet the needs of local people. Two Place Partnerships on the local authority footprints have been formed, which retain and further strengthen local place alliances. The Place Partnerships will have an ethos of equality between partners and be established to deliver a range of functions on behalf of the ICB and ICP. These will include:

- (a) co-ordinating and integrating local services built on a mutual understanding of the population and a shared vision;
- (b) taking accountability for the delivery of coordinated, high quality care and improved outcomes for their populations; and
- (c) the planning, management of resources, delivery, and performance of a range of community-based health and care services, in line with the strategic requirements of the ICB and ICP.

The overall approach will be a social model that is outcome driven and strength based; focussing on the assets of individuals and communities and developed with them through local leadership. There is a collective ambition for delegated responsibility and accountability to enable maximum impact from existing and enhanced structures.

1.1.6 Provider collaboratives are partnership arrangements involving two or more trusts (foundation trusts or NHS trusts and could also include community interest companies providing NHS care), that collectively work across multiple places to realise the benefits of mutual aid and working at scale. The purpose of provider collaboratives is to better enable their members to work together to continuously improve quality, efficiency, and outcomes, including proactively addressing unwarranted variation and inequalities in access and experience across different providers.

¹ It is a proposed common duty for NHS bodies that plan and commission services (NHS England and ICBs) and that provide services (Trusts and Foundation Trusts). It will oblige these bodies to consider the effects of their decisions on:

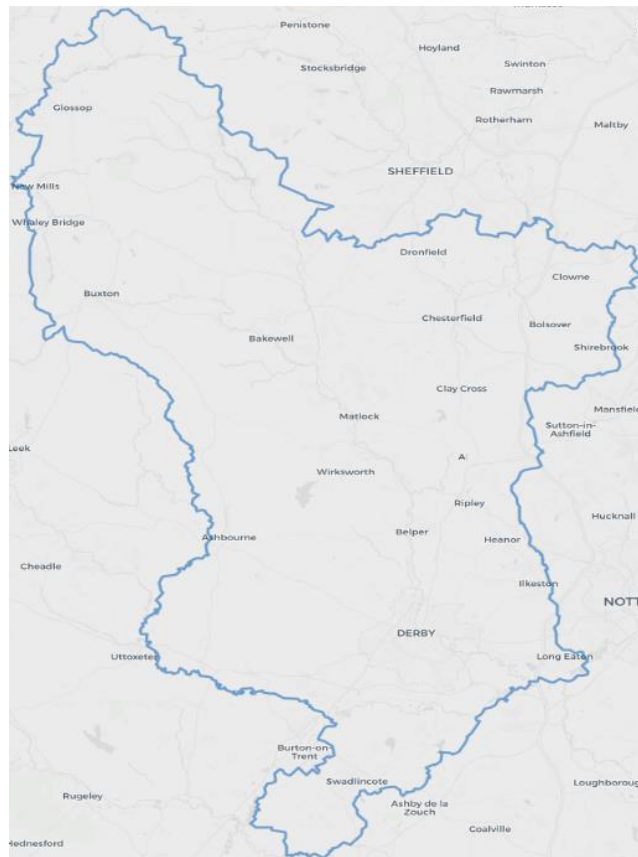
- the health and wellbeing of the people of England
- the quality of services provided or arranged by both themselves and other relevant bodies
- the sustainable and efficient use of resources by both themselves and other relevant bodies

1.2 Name

The name of this Integrated Care Board is NHS Derby and Derbyshire ICB² (“the ICB”).

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB³ is approximately 2,495 km² within Derbyshire and Derby City.⁴



1.3.2 As the ICB is fully coterminous with the areas covered by Local Authorities, the area covered by the ICB is defined by the Lower Layer Super Output Areas (LSOAs) as listed below.

1.3.3 The following are the District and Borough Councils and the Upper Tier Local Authority which the ICB covers, the:

- (a) County Council of Derbyshire
- (b) City Council of Derby
- (c) Borough of Chesterfield
- (d) Borough of High Peak (including Glossop)
- (e) Borough of Amber Valley
- (f) Borough of Erewash

- (g) District of Bolsover
- (h) District of North East Derbyshire
- (i) District of Derbyshire Dales
- (j) District of South Derbyshire
- (k) Peak District National Park Authority

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).⁵
- 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 www.ddicb.nhs.uk.
- 1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:
 - (a) having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);
 - (b) exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
 - (c) duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014);
 - (d) adult safeguarding and carers (the Care Act 2014);
 - (e) equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35);

- (f) information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000); and
 - (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 14Z40 (duty in respect of research),
 - (e) section 14Z43 (duty to have regard to effect of decisions);
 - (f) section 14Z45 (public involvement and consultation);
 - (g) sections 223GB to 223N (financial duties); and
 - (h) 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 14Z60 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 14Z61).
- 1.5 **Status of this Constitution**
- 1.5.1 The ICB was established on the 1st of July 2022 by The Integrated Care Boards (Establishment) Order 2022⁷ 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 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:
 - (a) where the ICB applies to NHS England in accordance with NHS England's published procedure⁶ and that application is approved; and

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

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

The Chief Executive Officer may periodically propose amendments to the Constitution which shall be considered and approved by the ICB Board members where:

- (c) changes are thought to have a material impact;
- (d) changes are proposed to the reserved powers of the members;
- (e) at least half (50%) of all the ICB board Members formally request that the amendments be put before the full ICB board members for approval.

Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved. This is set out in Appendix One, Standing Orders Section 4.9 Decision Making.

1.7 Related Documents

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

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

- (a) **Standing orders** – which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

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

- (a) **Scheme of Reservation and Delegation (SoRD)⁸** – sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.
- (b) **Functions and Decision Map⁹** – a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).
- (c) **Standing Financial Instructions** – which set out the arrangements for managing the ICB's financial affairs.

- (d) **The ICB Governance Handbook¹⁰** –This brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:
 - (i) The above documents (a) – (c);
 - (ii) terms of reference for all committees and sub-committees of the board that exercise ICB functions¹¹;
 - (iii) delegation arrangements¹² 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 of those organisations in accordance with section 65Z6 of the 2006 Act; and
 - (iv) 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.
 - (v) The up-to-date list of eligible providers of primary medical services under clause 3.7.2.
- (e) **Corporate Governance Framework** – brings together a range of corporate statutory documents in one place to assist in building a consistent corporate approach and forms part of the corporate memory.
- (f) **Governance Structure**
- (g) **Key policy documents¹³** which should also be included in the Governance Handbook or linked to it – including:
 - (i) Standards of Business Conduct Policy;
 - (ii) Conflicts of Interest Policy and Procedures; and
 - (iii) Policy for Public Involvement and Engagement.

2. COMPOSITION OF THE BOARD OF THE ICB

2.1 Background

- 2.1.1 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.
- 2.1.2 Further information about the individuals who fulfil these roles can be found on our website www.ddicb.nhs.uk.¹⁴

2.1.3 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.

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

2.1.5 NHS England Policy¹⁵, requires the ICB to appoint the following additional Ordinary Members:

- (a) three executive members, namely:
 - (i) Chief Finance Officer
 - (ii) Chief Medical Officer; and
 - (iii) Chief Nursing Officer.

And in addition to the two mandated Non-Executive Members for Audit and Remuneration there will be:

- (b) an additional two¹⁶ Non-Executive Members.

2.1.6 The Ordinary¹⁷ Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following, and appointed in accordance with the procedures set out in Section 3 below:

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

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

2.2 **Board Membership**

2.2.1 The ICB has five¹⁸ Partner Members

- (a) One NHS Trust and Foundation Trust Partner Member

- (b) One NHS Trust and Foundation Trust Partner member who shall have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.
- (c) One Primary Medical Services Partner Member; and
- (d) Two Local Authority Partner Members.

2.2.2 The ICB has also appointed the following further Ordinary Members to the board:¹⁹

- (a) Chief People Officer;
- (b) Chief Strategy and Delivery Officer (Deputy Chief Executive)
- (c) Clinical Lead Member.

2.2.3 The board is therefore composed of the following seventeen members:

- (a) Chair;
- (b) Chief Executive;
- (c) Two Partner Members NHS and Foundation Trusts
- (d) One Partner Member Primary Medical Services;
- (e) Two Partner Members Local Authorities;
- (f) Four Non-Executive Members, (one of which, but not the Audit Committee Chair, will be appointed Deputy Chair¹⁶; and one of which, who may be the Deputy Chair or the Audit Committee Chair; will be appointed the Senior Non-Executive Member;
- (g) One Clinical Lead Member;
- (h) Chief Finance Officer;
- (i) Chief Medical Officer;
- (j) Chief Nursing Officer;
- (k) Chief Strategy and Delivery Officer (Deputy Chief Executive); and
- (l) Chief People Officer.

2.2.4 The Chair will exercise their function to approve the appointment of the ordinary members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.²⁰

2.2.5 The board will keep under review the skills, knowledge, and experience that it considers necessary for members of the board to possess (when taken together) in order for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular Participants and Observers at Board Meetings²¹

- 2.3.1 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. Participants will be affiliated to the ICB Executive Team but will not be a member of the ICB.
- 2.3.2 Participants²² 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. Regular participants will include the following:
- (a) Chief of Staff (Board Secretary);²³
 - (b) Chair of the Clinical and Professional Advisory Committee;
 - (c) Chief Digital and Technology Officer;
 - (d) Chair of the Integrated Place Executive.
- 2.3.3 Observers²⁴ 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.
- 2.3.4 Participants and / or Observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the Standing Orders.

3. APPOINTMENTS PROCESS FOR THE BOARD

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”;²⁵
 - (b) be committed to upholding the Seven Principles of Public Life (known as the Nolan Principles); and
 - (c) fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification Criteria for Board Membership²⁶

- 3.2.1 A Member of Parliament.
- 3.2.2 A person whose appointment as a board member (“the candidate”) is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate’s involvement with the private healthcare sector or otherwise.²⁷

- 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, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 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.
- 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, meaning an individual who is a member of a profession regulated by a body mentioned in Section 25(3) of the National Health Service Reform and Health Care Professions Act 2002, 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**²⁸

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 clause 3.1, this member must fulfil the following additional eligibility criteria:

- (a) the Chair will be independent; and
- (b) must meet the core competencies identified for the role of Chair and be subject to performance appraisal.

3.3.3 Individuals will not be eligible if:

- (a) they hold a role in another health and care organisation within the ICB area;
- (b) any of the disqualification criteria set out in clause 3.2 apply;

- (c) any other exclusion criteria set out in the applicable NHS England guidance applies.
- 3.3.4 The term of office for the chair will be a maximum of 2 years and the total number of terms a chair may serve is 3²⁹ terms.
- 3.4 **Deputy Chair and Senior Non-Executive Member roles**
 - 3.4.1 The Deputy Chair is to be appointed from amongst the Non-Executive members by the board subject to the approval of the Chair.
 - 3.4.2 No individual shall hold the position of Chair of the Audit Committee and Deputy Chair at the same time.
 - 3.4.3 The Senior Non-Executive Member³⁰ is to be appointed amongst the non-executive members by the board subject to the approval of the Chair.
- 3.5 **Chief Executive**
 - 3.5.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.³¹
 - 3.5.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.³²
 - 3.5.3 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 19(4)(b) of Schedule 1B to the 2006 Act; and
 - (b) meets the requirements as set out in the Chief Executive role description and person specification.³³
 - 3.5.4 Individuals will not be eligible if:
 - (a) any of the disqualification criteria set out in clause 3.2 apply;
 - (b) subject to clause 3.5.3(a), they hold any other employment or executive role other than Chief Executive or another Integrated Care Board;
 - (c) the process of disqualification is to be overseen by NHS England and Improvement and the Independent Non-Executive Member for Audit.
- 3.6 **Partner Members – NHS Trusts and Foundation Trusts within the ICB area**
 - 3.6.1 These Partner Members are jointly³⁴ nominated by the NHS Trusts and/or FTs which provide services for the purpose of the health service within the ICB's area and meet the Forward Plan Condition or (if the Forward Plan Condition is not met) the Level of Services Provided Condition³⁵. Those Trusts and Foundation Trusts are:
 - (a) Chesterfield Royal Hospital NHS Foundation Trust;³⁶

- (b) Derbyshire Healthcare NHS Foundation Trust;
- (c) East Midlands Ambulance Services NHS Trust;
- (d) University Hospitals of Derby and Burton NHS Foundation Trust; and
- (e) Derbyshire Community Health Services NHS Foundation Trust.

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

- (a) be an Executive Director of one of the NHS Trusts or Foundation Trusts within the ICB's area³⁷ (from those listed at 3.6.1 above);
- (b) one member will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

3.6.3 Individuals will not be eligible if:

- (a) any of the disqualification criteria set out in clause 3.2 apply;
- (b) any other exclusion criteria set out in the applicable NHS England guidance applies;
- (c) a conflict of interest is evident, as determined by the Chair, which results in the individual being unable to fulfil the role.

3.6.4 These members will be appointed by³⁸ the Chief Executive subject to the approval of the Chair.

3.6.5 The appointment process will be as follows:³⁹

- (a) Joint Nomination
 - When a vacancy arises for the Partner Member (s) from the Trusts or Foundation Trusts, including where one of these roles is also the lead for mental health, each eligible organisation listed at 3.6.1 will be invited to make one nomination per vacancy.
 - Eligible organisations may nominate individuals from their own organisation or another organisation.
 - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within five working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.
- (b) Assessment, selection, and appointment subject to approval of the Chair under 3.6.5(c)
 - The full list of nominees will be considered by a panel convened by the Chief Executive.

- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.2 and 3.6.3.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

(c) Chair's approval

The Chair will determine whether to approve the appointment of the most suitable nominee as identified under 3.6.5(b).

3.6.6 The normal term of office⁴⁰ for these Partner Members will be 3 years but individual terms may change subject to that individual fulfilling their substantive position and the total number of terms they may serve is 3 as a maximum. However, after the sixth year it may be permissible to extend by a single year at a time up to a total of 9 years by exception. In normal circumstances, the appointment process set out at 3.6.5 of this constitution will be followed at the end of each term of office, and no individual will have the right to be automatically re-appointed. However, in exceptional circumstances, one term of office may be extended for a period of up to one year, subject to approval by the Chair.

3.7 Partner Member – Providers of Primary Medical Services

3.7.1 This Partner Member is jointly³⁴ nominated by providers of Primary Medical Services for the purposes of the health service within the ICB's area and are Primary Medical Services contract holders responsible for the provision of essential services, within core hours to a list of registered persons whom the ICB has core responsibility.⁴¹

3.7.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this Constitution.⁴²

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

- (a) be a health care professional from the Primary Medical Services;
- (b) meet the requirements as set out in the Partner Member – Primary Medical Services role description and person specification.⁴³

3.7.4 Individuals will not be eligible if:

- (a) any of the disqualification criteria set out in clause 3.2 apply;
- (b) any other exclusion criteria set out in the applicable NHS England guidance applies;
- (c) a conflict of interest is evident, as determined by the Chair, which results in the individual being unable to fulfil the role.

3.7.5 This member will be appointed by a panel⁴⁴ and approved by the Chair and the Chief Executive.

3.7.6 The appointment process will be as follows:³⁹

(a) Joint Nomination

- When a vacancy arises, each eligible organisation described at 3.7.1 and listed in the Governance Handbook will be invited to make one nomination per vacancy.
- The nomination of an individual must be seconded by 2 other eligible organisations. [seconding is most suitable when there are large numbers of nominating organisations].
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within five working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

(b) Assessment, selection, and appointment subject to approval of the Chair under 3.7.6(c)

- The full list of nominees will be considered by a panel convened by the Chief Executive
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.3 and 3.7.4
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

(c) Chair's approval

The Chair will determine whether to approve the appointment of the most suitable nominee as identified under 3.7.6(b).

3.7.7 The normal term of office⁴⁰ for this Partner Member will be 3 years and the total number of terms they may serve is 3 terms. In normal circumstances, the appointment process set out at 3.7.6 of this constitution will be followed at the end of each term of office, and no individual will have the right to be automatically re-appointed. However, in exceptional circumstances, one term of office may be extended for a period of up to one year, subject to approval by the Chair.

3.8 **Partner Members – Local Authorities**

3.8.1 These Partner Members are jointly³⁴ nominated by the local authorities whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

- (a) Derby City Council;
- (b) Derbyshire County Council.

3.8.2 This member will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:

- (a) be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at clause 3.8.1;⁴⁵
- (b) meet the requirements as set out in the Partner Member – Local Authority role description and person specification.
- (c) one of these members must have knowledge and experience in public health
- (d) one of these members must have knowledge and experience in child and adult social care

3.8.3 Individuals will not be eligible if:

- (a) any of the disqualification criteria set out in clause 3.2 apply;
- (b) any other exclusion criteria set out in the applicable NHS England guidance applies.

3.8.4 This member will be appointed by⁴⁶ the Chief Executive subject to the approval of the Chair.

3.8.5 The appointment process will be as follows:³⁹

- (a) Joint Nomination
 - When a vacancy arises, each eligible organisation listed at 3.8.1(a) will be invited to make one nomination per vacancy.
 - Eligible organisations may nominate individuals from their own organisation or another organisation.
 - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within five working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.
- (b) Assessment, selection, and appointment subject to approval of the Chair under 3.8.1(c)

- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.8.2 and 3.8.3.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

(c) Chair's approval

3.8.6 The Chair will determine whether to approve the appointment of the most suitable nominee as identified under 3.8.1(b). To support the appointment process for the above, the process for selection for the Local Authority Partner Members will be that the ICB will set out the requirements of the roles, namely and the upper tier local authorities will consider how best to serve the Board of the ICB with senior Officers from adults and children's social care and public health. The two Local Authority Members must therefore balance membership for each of those functions;

3.8.7 The normal term of office⁴⁷ for this Partner Member will be 2 years, and the total number of terms they may serve is 3 terms. In normal circumstances, the appointment process set out at 3.8.5 of this constitution will be followed at the end of each term of office, and no individual will have the right to be automatically re-appointed. However, in exceptional circumstances, one term of office may be extended for a period of up to one year, subject to approval by the Chair.

3.9 **Chief Medical Officer⁴⁸**

3.9.1 This member will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:

- (a) be an employee of the ICB⁴⁹ or a person seconded to the ICB who is employed in the civil service of the State or by any public authority in the UK;
- (b) be a registered Medical Practitioner;
- (c) meets the requirements as set out in the Chief Medical Officer role description and person specification.

3.9.2 Individuals will not be eligible if:

- (a) any of the disqualification criteria set out in clause 3.2 apply;
- (b) any other exclusion criteria set out in the applicable NHS England guidance applies.

3.9.3 This member will be appointed by⁴⁶ the Chief Executive, following a competitive process, subject to the approval of the Chair.

3.10 **Chief Nursing Officer**⁵⁰

3.10.1 This member will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:

- (a) be an employee⁵¹ of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by any public authority in the UK;
- (b) be a registered Nurse;
- (c) hold current valid registration with the Nursing and Midwifery Council;
- (d) meet the requirements as set out in the Chief Nursing Officer role description person specification.

3.10.2 Individuals will not be eligible if:

- (a) any of the disqualification criteria set out in clause 3.2 apply;
- (b) any other exclusion criteria set out in the applicable NHS England guidance applies.

3.10.3 This member will be appointed by⁴⁶ the Chief Executive, following a competitive process, subject to the approval of the Chair.

3.11 **Chief Finance Officer**⁵²

3.11.1 This member will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:

- (a) be an employee of the ICB⁵³ or a person seconded to the ICB who is employed in the civil service of the State or by any public authority in the UK;
- (b) be a qualified Accountant with full membership and evidence of up-to-date continuing professional development;
- (c) meets the requirements as set out in the Chief Finance Officer role description and person specification.

3.11.2 Individuals will not be eligible if:

- (a) any of the disqualification criteria set out in clause 3.2 apply;
- (b) any other exclusion criteria set out in the applicable NHS England guidance applies.

3.11.3 This member will be appointed by⁴⁶ the Chief Executive subject to the approval of the Chair.

3.12 **Four**⁵⁴ **Non-Executive Members**

3.12.1 The ICB will appoint four Non-Executive Members.

- 3.12.2 These members will be appointed and approved by the Chair⁵⁵ subject to the recruitment and selection process.
- 3.12.3 These members will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:
- (a) not be an employee of the ICB or a person seconded to the ICB;
 - (b) not hold a role in another health and care organisation in the ICS area;
 - (c) one shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee;
 - (d) another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee;
 - (e) one member should have specific knowledge, skills and experience that makes them suitable to take the role of a senior independent director and take a lead role in the appraisal of the ICB Chair. This may not be the Chair of the Audit Committee.⁵⁶
- 3.12.4 Individuals will not be eligible if:
- (a) any of the disqualification criteria set out in clause 3.2 apply;
 - (b) they hold a role in another health and care organisation within the ICB area;
 - (c) any other exclusion criteria set out in the applicable NHS England guidance applies;
 - (d) a conflict of interest is evident, as determined by the Chair, which results in the individual being unable to fulfil the role.
- 3.12.5 The usual term of office for a Non-Executive Member will be 3 years and the total number of terms an individual may serve is 2⁵⁷ terms with the potential to renew annually up to a maximum of 3 full terms (9 years).
- 3.12.6 In order to avoid a majority of the Non-Executive Member terms ending simultaneously⁵⁸, the Chair and Chief Executive will set the length of the initial term of office at between 2 and 3 years on a staggered basis across the roles.
- 3.12.7 Subject to⁵⁹ satisfactory performance assessed through appraisal the ICB Chair may approve the re-appointment of a Non-Executive Member up to the maximum number of terms permitted for their role.

3.13 **Other Board Members**⁶⁰

3.13.1 Chief People Officer

- (a) This member will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:

- (i) 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 any public authority in the UK;
 - (ii) meets the requirements as set out in the Chief People Officer role description and person specification
- (b) Individuals will not be eligible if:
 - (i) any of the disqualification criteria set out in clause 3.2 apply;
 - (ii) any other exclusion criteria set out in the applicable NHS England guidance applies;
- (c) This member will be appointed by the Chief Executive subject to the approval of the Chair.

3.13.2 Clinical Lead Member (Clinical Chair of Quality and Performance Committee)

- (a) This member will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:
 - (i) Will need to meet the requirements as set out in the Clinical Lead role description and person specification.
- (b) Individuals will not be eligible if:
 - (i) any of the disqualification criteria set out in clause 3.2 apply;
 - (ii) any other exclusion criteria set out in the applicable NHS England guidance applies.
- (c) This member will be recruited, selected and appointed on a contract for services by the Chief Executive, subject to the approval of the Chair.

3.13.3 Chief Strategy and Delivery Officer (Deputy Chief Executive)

- (a) This member will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:
 - (i) 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 any public authority in the UK ;
 - (ii) meets the requirements as set out in the Chief Strategy and Delivery Officer (Deputy Chief Executive) role description and person specification
- (b) Individuals will not be eligible if:
 - (i) any of the disqualification criteria set out in clause 3.2 apply;
 - (ii) any other exclusion criteria set out in the applicable NHS England guidance applies;

- (c) This member will be appointed by the Chief Executive subject to the approval of the Chair.

3.13.4 Regular Participants

- (a) These participants will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:
 - (i) Chief of Staff (Board Secretary);
 - (ii) Chair of Clinical and Professional Leadership Group (who will be a clinician);
 - (iii) Chief Digital and Technology Officer; and
 - (iv) Chair of the Integrated Place Executive.
- (b) Individuals will not be eligible if:
 - (i) any of the disqualification criteria set out in clause 3.2 apply; any other exclusion criteria set out in the applicable NHS England guidance applies;
- (c) The above participants will be appointed by the Chief Executive subject to the approval of the Chair.

3.14 Board Members: Removal from Office

3.14.1 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.

3.14.2 With the exception of the Chair, board members shall be removed from office if any of the following occurs:

- (a) if they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance;
- (b) if they fail to attend a minimum of 50% of the meetings to which they are invited unless agreed with the Chair in extenuating circumstances;⁶¹
- (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 dishonesty; 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;
- (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;
 - (g) if the role is no longer required (e.g. restructuring).
- 3.14.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in clause 3.14.2 apply.
- 3.14.4 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.
- 3.14.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State for Health and Social Care.
- 3.14.6 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.
- 3.15 **Terms of Appointment of Board Members**
 - 3.15.1 With the exception of the Chair and Non-Executive Members, arrangements for remuneration⁶² and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published www.ddicb.nhs.uk and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-Executive Members will be set by the Chief Executive.⁶²
 - 3.15.2 Other terms of appointment will be determined by the Remuneration Committee.
 - 3.15.3 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 code of conduct and behaviours⁶³ which sets out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB Code of Conduct and Behaviours is published in the Governance Handbook.

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;
- (e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England; and
- (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 clause 4.2.1(a) – (f) 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 Scheme of Reservation and Delegation.

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 www.ddicb.nhs.uk.

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

4.4.3 The SoRD sets out:

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

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

4.5 **Functions and Decision Map**

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

4.5.2 The Functions and Decision Map is published www.ddicb.nhs.uk.

4.5.3 The map includes:

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

4.6 **Committees and Sub-Committees⁶⁴**

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 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the Board⁶⁵. All terms of reference are published in the Governance Handbook.

- 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 under terms of reference and membership agreed by the ICB as relevant. Appropriate reporting and assurance mechanisms must be developed as part of agreeing terms of reference for Committees and Sub-Committees and reported to the board;⁶⁶
 - (b) ensure that committee terms of reference are approved by the board and aligned with the SoRD;
 - (c) ensure membership of the committees are specified by the board;
 - (d) provide reports to the board on their activities at agreed intervals;
 - (e) attend board Meetings at the invitation of the Chair;
 - (f) comply with the outputs of internal audit findings and committee effectiveness reviews;
 - (g) submit to the ICB board a decision and assurance report following each Committee meeting;
 - (h) submit their confirmed minutes to the ICB board for assurance;
 - (i) comply with agreed internal audit findings and committee effectiveness reviews;
 - (j) demonstrate consideration of the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity;
 - (k) ensure that members abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.
- 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 that exercise the ICB commissioning functions will be approved by the Chair⁶⁵. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise
- 4.6.7 All members of committees and sub-committees are required to act in accordance with this Constitution, including the standing orders as well as the SFIs and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

- (a) **Audit Committee⁶⁷** – 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 a Non-Executive Member (other than the Chair and Deputy Chair¹⁶ of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters;

- (b) **Remuneration Committee⁶⁸** – 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 Committee will be chaired by a Non-Executive Member other than the ICB Chair or the Chair of Audit Committee.

4.6.9 The terms of reference for each of the above committees are published in the Governance Handbook.⁶⁹

4.6.10 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 published⁷⁰ in the Governance Handbook.

4.7 **Delegations made under section 65Z5 of the 2006 Act**

4.7.1 As per clause 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 delegation⁷¹. 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 accountable⁷² 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 DECISIONS⁷³

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:
- (a) conducting the business of the ICB;
 - (b) the procedures to be followed during meetings; and
 - (c) 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 Orders⁷⁴ is included in Appendix 1 and form part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

- 5.2.1 The ICB has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD.
- 5.2.2 A copy of the SFIs published in the Governance Handbook available www.ddicb.nhs.uk.

6. ARRANGEMENTS FOR CONFLICT OF INTEREST MANAGEMENT AND STANDARDS OF BUSINESS CONDUCT

6.1 Conflicts of Interest⁷⁵

- 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 private⁷⁶ 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 www.ddicb.nhs.uk.⁷⁷
- 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.⁷⁸

6.1.6 The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian⁷⁹. 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**⁸⁰

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

6.2.1 decision-making will be open and transparent, will be inclusive and incorporate diverse views across the system. Decisions will be made in the interests of the health of the population and consistent with the statutory responsibilities of the ICB and ICS. Any individual involved in decisions relating to the ICB functions must be acting in the interests of the people of Derby and Derbyshire rather than furthering direct or indirect financial, personal, professional, or organisational interests. Decision making will be devolved to Place where appropriate.

6.2.2 the ICB has been created to give statutory NHS providers, local authority, and primary medical services (general practice) nominees a role in decision-making. These individuals will be expected to act in accordance with section 6.2.1(a), and it should not be assumed that they are personally or professionally conflicted by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations;

6.2.3 the personal and professional interests of all ICB board members, ICB committee members and ICB staff who are involved in decision taking must be declared, recorded and managed appropriately. Declarations must be made as soon as practicable after the person becomes aware of the conflict or potential conflict and, in any event, within 28 days of the person becoming aware. This includes being

clear and specific about the nature of any interest, and about the nature of any conflict that may arise regarding a particular decision;

- 6.2.4 actions to mitigate conflicts of interests should be proportionate and should seek to preserve the spirit of collective decision-making wherever possible. Mitigation should take account of a range of factors including the impact that the perception of an unsound decision might have, and the risks and benefits of having a particular individual involved in making the decision;
- 6.2.5 the ICB will clearly distinguish between those individuals who should be involved in formal decision taking, and those whose input informs decisions, including shaping the ICB's understanding of how best to meet patients' needs and deliver care for their populations. The way conflicts of interest are managed should reflect this distinction. For example, where independent providers (including the VCSE sector) hold contracts for services it would be appropriate and reasonable for the body to involve them in discussions, for example about pathway design and service delivery, particularly at place-level. However, this would be clearly distinct from any considerations around contracting and commissioning, from which they would be excluded;
- 6.2.6 where decisions are being taken as part of a formal competitive procurement of services, any individual who is associated with an organisation that has a vested interest in the procurement should excuse themselves from the process; and
- 6.2.7 the way conflicts of interest are declared and managed will contribute to a culture of transparency about how decisions are made.

6.3 **Declaring and Registering Interests**

- 6.3.1 The ICB maintains registers⁸¹ of the interests of:
 - (a) Members of the ICB;
 - (b) Members of the board's committees and sub-committees; and
 - (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 www.ddicb.nhs.uk.⁸²
- 6.3.3 All relevant persons as per clauses 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 on appointment and during relevant discussion in meetings.
- 6.3.5 All declarations will be entered in the registers as per clause 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 Interests⁸³ (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

- 7.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.
- 7.2 **Principles⁸⁴**
- 7.2.1 Subsidiarity: arrangements should be designed to facilitate decisions being taken as close to local communities as possible, and at a larger scale where there are clear benefits from collaborative approaches and economies of scale.
- 7.2.2 Population-focused vision: decisions should be consistent with a clear vision and strategy that reflects the four core purposes.
- 7.2.3 Shared understanding: partners should have a collective understanding of the opportunities available by working together and the impact of individual organisational decisions on other parts of the system.
- 7.2.4 Co-design and co-production: addressing system challenges and decision-making should involve working with people, communities, clinicians, and professionals in

an equal way, sharing influence, skills and experience to design, deliver and monitor services and projects.

7.2.5 Timely access to information and data: system partners should share accurate and complete data (quantitative and qualitative) in an open and timely manner to enable effective decision-making.

7.2.6 Clear and transparent decision-making: system partners should work in an open way ensuring that decision-making processes stand up to independent scrutiny.

7.2.7 Accountability: arrangements should be in line with the accountability framework and to each other.

7.3 **Meetings and publications**

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

7.3.2 Papers and minutes of all meetings held in public⁸⁵ will be published.

7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

7.3.5 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.

7.3.6 Information will be provided to NHS England as required.

7.3.7 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 Interests⁸⁶;

(c) key policies.

7.3.8 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 "Joint Forward Plan"). The plan will, in particular:

(a) Describe the health services for which the ICB proposes to make arrangements in the exercise of its functions;;

(b) Explain how the ICB proposes to discharge its duties under 14Z34 to 14Z45 (general duties of integrated care boards) and sections 223GB and 223N (financial duties):

- (c) Set out any steps that the ICB proposes to take to implement the Derby City and Derbyshire County joint local health and wellbeing strategies⁸⁷.
- (d) Set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25;
- (e) Set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether children or adults).

7.4 Scrutiny and Decision Making

- 7.4.1 At least three 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.
- 7.4.2 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.
- 7.4.3 The ICB will comply with the requirements of the NHS Provider Selection Regime, including complying with existing procurement rules until the provider selection regime comes into effect.⁸⁸
- 7.4.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.5 Annual Report

- 7.5.1 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. An annual report must in particular:
 - (a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)
 - (b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)
 - (c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and
 - (d) review any steps that the ICB has taken to implement any joint local 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 Committee⁸⁹ which is chaired by a Non-Executive Member other than the Chair or Audit Chair.
- 8.3 The membership of the Remuneration Committee is determined by the board. No employees may be a member of the Remuneration Committee but the board will ensure that the Remuneration Committee has access to appropriate advice by:
 - 8.3.1 permitting the Remuneration Committee to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions, provided that it follows any procedures put in place by the ICB for obtaining legal or professional advice;
 - 8.3.2 the Human Resources Advisor may act as an attendee to the Remuneration Committee.
- 8.4 The board may appoint independent members or advisers to the Remuneration Committee who are not members of the board.
- 8.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in relating to paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published in the Governance Handbook.
- 8.6 The duties of the Remuneration Committee include:⁹⁰
 - 8.6.1 setting the ICB remuneration policy (or equivalent) and standard terms and conditions;
 - 8.6.2 making arrangements to pay employees such remuneration and allowances as it may determine;
 - 8.6.3 set remuneration and allowances for members of the board;
 - 8.6.4 set any allowances for members of committees or sub-committees of the ICB who are not members of the board;
 - 8.6.5 for the Chief Executive, Directors and other Very Senior Managers; determine all aspects of remuneration including but not limited to salary (including any performance-related elements), bonuses, pensions and cars;
 - 8.6.6 determine arrangements for termination of employment and other contractual terms and non-contractual terms;
 - 8.6.7 for all staff; determine the ICB remuneration policy (including the adoption of remuneration frameworks such as Agenda for Change);
 - 8.6.8 oversee contractual arrangements;

- 8.6.9 determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate;
- 8.6.10 oversee the arrangements for the performance review for Directors/Senior Managers;
- 8.6.11 receive assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and Proper Person Regulation (FPPR);
- 8.6.12 setting the ICB remuneration policy (or equivalent) and standard terms and conditions;
- 8.6.13 set any allowances for members of committees or sub-committees of the ICB who are not members of the board; and
- 8.6.14 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 14Z45(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:
 - 9.1.1 the planning of the commissioning arrangements by the Integrated Care Board;
 - 9.1.2 the development and consideration of proposals by the ICB 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
 - 9.1.3 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 14Z54 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:
 - 9.2.1 use our engagement model to put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS to ensure the voices of patients, service users, communities and staff are involved and that their insights are sought and utilised;
 - 9.2.2 co-produce and redesign services and tackle system priorities in partnership with people and communities;

- 9.2.3 engender a culture of continuous engagement with people and communities and work with Healthwatch and community leaders as key partners;
- 9.2.4 build on the engagement assets of all partners in the ICS – networks, relationships, activity in local places;
- 9.2.5 start engagement at a formative stage when developing plans and feed back to people and communities how it has influenced activities and decisions;
- 9.2.6 understand our community's needs, experience and aspirations for health and care, using engagement to find out if change is working;
- 9.2.7 build relationships with excluded or harder to reach groups – especially those affected by inequalities – and create opportunities to engage where they do not currently exist;
- 9.2.8 provide clear and accessible public information about vision, plans and progress to build understanding and trust; and
- 9.2.9 govern our engagement strategy and activities through the relevant committee.
- 9.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities.⁹¹
 - 9.3.1 put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS;
 - 9.3.2 start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions;
 - 9.3.3 understand the community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect;
 - 9.3.4 build relationships with excluded groups – especially those affected by inequalities;
 - 9.3.5 work with Healthwatch and the voluntary, community and social enterprise sector as key partners;
 - 9.3.6 provide clear and accessible public information about vision, plans and progress to build understanding and trust;
 - 9.3.7 use community development approaches that empower people and communities, making connections to social action;
 - 9.3.8 use co-production, insight and engagement to achieve accountable health and care services;
 - 9.3.9 co-produce and redesign services and tackle system priorities in partnership with people and communities; and
 - 9.3.10 learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.
- 9.4 In addition the ICB has agreed the following:⁹²

- 9.4.1 these principles will be used when developing and maintaining arrangements for engaging with people and communities;
- 9.4.2 these arrangements, include:⁹³
- (a) a Communications and Engagement Strategy that is frequently reviewed by the ICB and where delivery is overseen by the relevant committee;⁹⁴
 - (b) ensure arrangements are put in place that enable patient and public involvement at local Place level, and in the work of Provider Collaboratives;
 - (c) appointment of a Non-Executive Member with a specific role to seek assurance on the ICB's arrangements for discharging its duties in relation to patient and public involvement;
 - (d) deployment of our assets to support engagement, including:
 - (i) our Citizen's Panel;
 - (ii) our Online Engagement Platform;
 - (iii) the System Insight Group and insight library;
 - (iv) ensuring sufficient expertise, training and resources are available to support effective engagement;
 - (v) arranging system-wide and place-based events and activities to speak to all stakeholders, including the ongoing deployment of our Derbyshire Dialogue model of online engagement.

Appendix 1 – Standing Orders

1. INTRODUCTION⁹⁵

These Standing Orders have been drawn up to regulate the proceedings of NHS Derby and Derbyshire 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.⁹⁶

2. AMENDMENT AND REVIEW

- 2.1 The Standing Orders are effective from the 1st of July 2022.⁹⁷
- 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 section 5.1 of the Constitution.
- 2.4 All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. INTERPRETATION, APPLICATION AND COMPLIANCE

- 3.1 Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 2.
- 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 the Executive Director of Corporate Affairs will provide a settled view which shall be final.
- 3.5 All members of the board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.
- 3.6 If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the board for action or ratification and the Audit Committee for review.

4. MEETINGS OF THE INTEGRATED CARE BOARD

4.1 Calling Board Meetings⁸⁵

- 4.1.1 Meetings of the board of the ICB shall be held at regular intervals⁹⁸ at such times and places⁹⁹ 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; and
 - (c) in emergency situations the Chair may call a meeting with two days'¹⁰⁰ 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 meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.
- 4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed if 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 shall preside over meetings in the Chair's stead¹⁶.
- 4.2.3 If both the Chair and Deputy Chair are absent or disqualified from participating by a conflict of interest a member of the ICB Board, committee or sub-committee retrospectively shall be chosen by members present, or by a majority of them, and shall preside.
- 4.2.4 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 Chair¹⁰¹ 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 www.ddicb.nhs.uk.

4.4 **Petitions**¹⁰²

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

4.5 **Nominated Deputies**¹⁰³

- 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. The deputy may speak and vote on their behalf. Partner Members and Executive Directors will ensure the attendance of a nominated deputy at all meetings where they are unable to attend.
- 4.5.2 The decision of the person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6 **Virtual attendance at meetings**¹⁰⁴

The board of the ICB 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.

4.7 **Quorum**¹⁰⁵

- 4.7.1 The quorum for meetings of the Board will be at least 7 members, including:
- (a) ICB Chair; plus
 - (b) either the Chief Executive, Chief Strategy and Delivery Officer (Deputy Chief Executive) or the Chief Finance Officer;
 - (c) either the Chief Medical Officer, or the Chief Nursing Officer.
 - (d) at least two Non-Executive Members; and
 - (e) at least two Partner Members.

- 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;
 - (c) A nominated deputy permitted in accordance with standing order 4.5 will count towards quorum for meetings of the board;
- 4.7.3 for all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.
- 4.8 **Vacancies and defects in appointments**
- 4.8.1 The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.¹⁰⁶
- 4.8.2 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:
- (a) a representative from the specific category where the vacancy or defect exists would attend.
- 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 through 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.¹⁰⁷ 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 Observers¹⁰⁸ (as detailed within paragraph 2.2 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; and

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

4.9.3 Disputes

Where helpful, the board may draw on third party support to assist them in resolving any disputes, such as peer review or mediation by NHS England.

4.9.4 Urgent decisions

- (a) In the case of 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.
- (b) The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair (or Vice Chair in the Chair's absence) and Chief Executive (or Deputy Chief Executive in the Chief Executive's absence)¹⁰⁹ subject to every effort having been made to consult with as many board members as possible in the given circumstances.
- (c) The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit Committee for oversight.

4.10 **Minutes**

- 4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.
- 4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.
- 4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.
- 4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11 **Admission of public and the press**

- 4.11.1 In accordance with Public Bodies (Admission to Meetings) Act 1960 All meetings of the board and all meetings of committees which are comprised of entirely board members or all board members 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 board'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 to 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 two 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 Integrated Care Board's seal

The ICB may have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature:

- 6.1.1 the Chief Executive;
- 6.1.2 the Chief Finance Officer;
- 6.1.3 the Chief of Staff (Board Secretary).

6.2 Execution of a document by signature

The following individuals are authorised to execute a document on behalf of the ICB by their signature.

- 6.2.1 the Chief Executive;
- 6.2.2 the Chief Finance Officer;
- 6.2.3 the Chief of Staff (Board Secretary).

Appendix 2 – 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.
ICB board	Members of the ICB.
Area	The geographical area that the ICB has responsibility for, as defined in clause 1.3 of this Constitution.
Committee	A committee created and appointed by the ICB board.
Sub-Committee	A committee created and appointed by and reporting to a committee.
Forward Plan Condition	The ‘Forward Plan Condition’ as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Level of Services Provided Condition	The ‘Level of Services Provided Condition’ as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Governance Handbook	The ICB Governance Handbook the contents which are described in section 1.7.3 (d)
Integrated Care Partnership	The joint committee for the ICB’s area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB’s area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Provider Collaborative	NHS Trusts working together to achieve better outcomes for people and ensure sustainable services in the future.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	<p>Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are appointed in accordance with the procedures set out in Section 3 having been nominated by the following:</p> <ul style="list-style-type: none"> NHS trusts and foundation trusts who provide services within the ICB’s area and are of a prescribed description

	<ul style="list-style-type: none"> the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description <p>the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.</p> <p>NHS England expects, so the ICB achieves ongoing compliance, that this requirement will be met through appointment against appropriate criteria of: a Partner Member (jointly nominated by all NHS trusts/foundation trusts, additional to the minimum of one partner member of each category required by the Act); or a separately appointed board member (i.e. not jointly nominated) likewise normally a mental health trust/foundation trust executive which could be a Chief Executive; or, where appropriate, an ICB executive director for mental health .*</p>
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
Health Care Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002
	ICBs should add local definitions as required and should always include any local terms that refer to legally prescribed roles or functions.

ICB Model Constitution Supporting Notes

The purpose of the supporting notes is to provide additional information, advice and explanations for ICBs considering applying to NHS England to amend their constitution in accordance with the relevant guidance.

¹ A mandatory statement has been included in the model constitution and adopted by all ICBs. ICBs may add further local context to the statement but should not change or remove any wording. ICBs may also wish to draw out the mutual accountability agreed between the partners and refer to the triple aim (see below).

None of these details need to be included in the Constitution legally, but there may be local benefit to signal these in a prominent place. Reference might be made here to the integrated care partnership (ICP) and arrangements made to align this Constitution with its terms of reference.

The triple aim is a common duty for NHS bodies that plan and commission services (NHS England and ICBs) and that provide services (NHS trusts and foundation trusts) to consider:

- the effects of their decisions on the health and wellbeing of the people of England
- the quality of services provided or arranged by both themselves and other relevant bodies
- the sustainable and efficient use of resources by both themselves and other relevant bodies

² The name used here must be the exact name used in the establishment order.

³ The area covered by the ICB is determined by The Integrated Care Boards (Establishment Order) 2022 (as amended).

⁴ The description of the area must match that on the establishment order; see Note 3 above.

⁵ NHS England has confirmed the delegation of some of its direct commissioning functions to ICBs, and to establish joint arrangements in respect of other functions. ICB constitutions do not need to be amended to introduce any such delegations or joint commissioning arrangements.

⁶ NHS England has published a procedure for ICBs to follow in applying to amend their Constitution. NHS England has published a separate process here whereby ICBs applying to amend their boundaries require the support of the affected ICBs and local authorities.

⁷ This section should be used to set out the procedure for variations. This should include as a minimum: who may propose a change to the Constitution and how this is done, who will be consulted on any proposed changes and how the decision (typically this will be the board) about proposed changes will be taken prior to an application being made to NHS England. These arrangements are for local determination and the process should comply with the ICB legal duties as a minimum.

⁸ A guide to developing a scheme of reservation and delegation (SoRD) has been prepared by NHS England with support from the Healthcare Financial Management Association.

⁹ It will be for each ICB to determine whether, and to which committee or part of the system, its functions will be delegated; in accordance with secondary legislation ([The National Health Service \(Joint Working and Delegation Arrangements\) \(England\) Amendment Regulations 2023](#)) and with regard to statutory guidance on the FutureNHS platform on delegation to other statutory bodies.

¹⁰ There is no reason why an ICB could not call the Governance Handbook by an alternative name to suit local arrangements, but it must be clear where things are published.

¹¹ The terms of reference for committees and sub-committees will need to be published and easily accessible. This is to fulfil the requirement for the Constitution to specify the arrangements made by the ICB to outline the transparency of its decision-making. Terms of reference can also supplement the functions and decision map and work together with any delegation arrangements that are part of the arrangements for the exercise of the ICB's functions.

¹² As a minimum, a summary of the delegation arrangements and the basis on which they are agreed should be published.

¹³ ICBs should publish key policies relating to governance arrangements in their Governance Handbook or be clearly linked to it.

¹⁴ ICBs may choose, in line with usual practice, to publish an introduction to their board members on their websites. Details of the individuals are not required within the Constitution.

¹⁵ These director roles may be filled in a range of possible ways. For example, different job titles may be used, and individuals may hold other responsibilities as well as filling this role. ICBs can change the wording here to reflect locally agreed arrangements within the agreed NHS England policy.

¹⁶ A minimum of 2 non-executive members are required; ICBs may appoint more.

One of the non-executive members, but not the audit committee chair, will be appointed the deputy chair of the board. The deputy chair will chair board meetings when the chair is absent, or the position of chair is vacant and may perform other activities to support the continued functioning of the board.

However, the deputy chair shall not exercise powers expressly reserved to the chair by Schedule 1B of the NHS Act 2006 such as the appointment of the chief executive. The ICB should confirm the scope of the deputy chair's role in writing.

¹⁷ 'Ordinary members' is the term used in the Act to describe members who are not the chair and chief executive.

¹⁸ The Act requires at least one from each sector. ICBs may decide to have more.

¹⁹ ICBs may add further members beyond the statutory minimum and NHS England policy requirements. All additional members of the board must be specified in the Constitution, including any additional partner, executive or non-executive members.

When designing the board membership, there will be a need to ensure balance of perspectives on the board. This will include, for example, ensuring that the perspectives of all sectors and types of providers within the ICB's area are included (for example, acute, mental health, community and specialist).

ICBs will need to ensure that the views and perspectives of patients, carers and the public are heard and included in the board decision-making process along with those from clinical and professional groups, under-represented communities and different geographical perspectives.

A board made up from diverse individuals, backgrounds and perspectives will be more likely to make the best decisions for its communities.

Beyond the composition of the board itself, ICBs should ensure there are mechanisms for how the full range of perspectives is included using the decision-making model and structures that the ICB employs.

ICBs will also be expected to comply with good governance practices, eg on board size, to allow appropriate decision-making to take place. Amendments to constitutions are subject to NHS England approval, including board membership.

²⁰ The chair is required to exercise their approval function in relation to the appointment of the ordinary members with a view to ensuring that at least one of the ordinary members has knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

This requirement is met through appointment against appropriate criteria of: a partner member (jointly nominated by all NHS trusts/foundation trusts; additional to the minimum of 1 partner member of each category required by the Act); a separately appointed board member (that is, not jointly nominated) likewise normally a mental health trust/foundation trust chief executive; or, where appropriate, an ICB executive director for mental health.

²¹ This whole section is entirely optional. The clauses are crafted to help systems articulate local arrangements clearly and may require some editing. There is only a need to use them if there is local discussion proposing the idea of 'non-voting' members (which are not permitted). The term 'non-voting member' should not be used here because an individual is either a member and may vote or they are not a member and hence may not vote. ICBs that opt to use this section should use the term 'participants and observers'.

²² Having regular participants recognises that some local partners will attend every meeting and, while they do not formally take part in decision-making, their views are sought, listened to and valued. It is recommended to limit the number of participants as most parties will play their largest role in the ICP or in operational forums and task and finish groups.

A distinction is drawn here between participants and observers as some organisations have previously had difficulty being clear about roles and what behaviours, permissions and privileges are extended to such individuals. ICBs can set out the expectations clearly from the outset.

²³ This is optional. It is not a requirement to list participants and observers in constitutions.

²⁴ This is not a requirement and suggested wording is offered for those organisations that have indicated that it would be helpful to identify specified individuals who are invited to meetings and receive papers in advance but do not have any speaking or participation rights. In practice, the status of these individuals is no different status from that of members of the public, but some organisations have found this approach useful in developing and managing local relationships.

²⁵ Regulation 5 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014 sets out the 'fit and proper person test'. An ICB's constitution requires that board members comply with the Fit and Proper Person Test which has been updated to take account of the Kark Review. See [NHS England guidance](#) published in August 2023.

²⁶ Any additional locally agreed disqualification criteria should be added to the list. Following consideration by Parliament, it was decided that being a councillor should not be a disqualification criterion. This does not alter the requirement for all ICB board members to be subject to an ICB selection process prior to the chair approving, or not, their appointment; and for partner members to be jointly nominated.

²⁷ The Act puts beyond doubt that it is not an attempt to privatise the NHS. It has been framed deliberately broadly, to reflect the wide range of potential circumstances that would render someone unsuitable to sit on an ICB board.

²⁸ In some cases, the Chair of the board may also be appointed to the role of chair of the ICP.

²⁹ To avoid impairing independence, chairs should normally serve a maximum of 6 years in the post of chair and a maximum of 9 years as a board member, which is consistent with the Code of Governance for trusts. A chair may serve longer than 6 years following a rigorous review at that point to ensure their ongoing independence; the NHS England regional director will liaise with ICB chairs to ensure a large number of chairs and non-executive board members do not step down simultaneously.

The drafting allows for interim chairs to be appointed for a shorter period while a substantive chair is recruited. Interim chair appointments are made by NHS England with the approval of the Secretary of State allowing them to exercise a chair's powers under the Act (for example, appoint a chief executive of the ICB), unlike the deputy chair, who is appointed by the board from among the non-executive members and subject to the approval of the chair.

³⁰ In accordance with governance requirements of NHS trusts regarding senior independent directors, one of the non-executive members must be appointed the

senior non-executive member. They may be the deputy chair or the chair of the audit committee.

The regional director, to whom the chair is accountable, should agree the role of the senior non-executive member in the appraisal of the chair and in ensuring the chair's compliance with the Fit and Proper Person Test.

The senior non-executive member is also expected to act as a sounding board for the chair and if necessary mediate between the chair and other board members.

³¹ The appointment is made by the chair of the board with approval from NHS England.

³² NHS England may set out how chairs and chief executives will be appointed and how those appointments proposed by ICBs will be approved.

³³ ICBs should add any additional criteria.

³⁴ ICBs need to ensure that their nomination processes fulfil the requirements of being 'jointly nominated'. A process would not be joint if the nominating organisations do not, together, have an opportunity to make the nominations, or if eligible organisations were excluded or censored.

The nominations would be joint if the nominating organisations can achieve full consensus on one or more nominees, which may be possible among trusts/foundation trusts and among local authorities but is unlikely to be practicable when there are large numbers of organisations involved (for example, primary care partners).

To be 'joint' it is not necessary for the nominating organisations to achieve full consensus on who should be nominated: the nominating organisations could approve, by majority, a list of individuals to be nominated. It is recommended that nil responses should be taken as assent to the list going forward to the ICB, to avoid a low response rate disrupting the process (particularly where there many organisations are involved).

ICBs could choose to add a requirement that individuals proposed for nomination should be able to demonstrate support from a sufficient (set out in the Constitution) number of nominating organisations (this could be useful, for example, for GP practices, where there could be many proposed nominees).

The use of elections to identify nominees is very strongly discouraged: not only does it risk marginalising organisations in the minority (for example, local authorities in the political minority, mental health trusts/foundation trusts or GPs working in particular area), it also risks the nomination of individuals who are well-known rather than best suited to contributing to the ICB unitary board.

³⁵ Please note the Regulations prescribe this, including setting out the forward plan condition and the level of services provided condition. Explanation of the rules prescribed by the regulations is given in the guidance to which this model constitution and notes form an annex.

³⁶ This refers to NHS trusts and foundation trusts that provide services within the ICB area and are of the description prescribed in the [Regulations](#) (gov.uk).

³⁷ This guidance states this will often be the chief executive.

³⁸ It is a requirement that the Constitution sets out who appoints the ordinary members. All appointments of ordinary members must (a requirement of the Act) be subject to the approval of the chair. The chair must always retain the right to reject/appoint individuals to result in a properly equipped board that collectively has the right skills, experience and attributes to be effective.

Therefore, constitutions should not specify any criteria that result in a single individual being identified from a nomination process, such as by identifying holders of a specific role (for example, it may not specify that the chief executive of local authority X will be appointed).

³⁹ Describing the nomination and selection process is difficult and therefore some model wording is provided. The wording itself is not compulsory and therefore shown in green text, but a clear description of the process is required, and it must comply with the legal framework and the NHS England guidance to which this model constitution and notes are an annex.

ICBs proposing to depart from the model wording should first check these notes to see if what they are proposing will be permitted. If there are any uncertainties, advice should be sought from the relevant regional lead. The following text provides further advice:

- The Constitution must set out the appointment process in full and should be clear and unambiguous.
- All 3 stages of the process should be outlined, but detail, such as to which mail address nominations should be returned to, are not required.
- Enduring criteria for the roles are set out in the Constitution along with disqualification criteria. These should be combined with more detailed requirements in a role description and person specification shared with nominating organisations before the process begins.
- The Constitution should identify eligible NHS trust/foundation trust and local authorities that may take part in the nomination process. A list of eligible GP providers should be included in the Governance Handbook (which does not form part of the constitution).
- It should specify how many nominations each eligible organisation may make.
- If there is to be a seconding requirement (this may be especially helpful when there is potential for large numbers of nominees), it should specify how many eligible organisations are required to second a nomination for it to be validated.
- The partner members of the board are not representatives of their sectors and rather must be selected on the basis of their suitability to fulfil the role on the ICB unitary board. Therefore, it is considered that running an election to identify a nominated individual would not be a suitable mechanism for nomination and would risk the marginalisation from the process of practices, councils or trusts in the minority.

-
- It should be clear how the 'joint' element of nomination will be achieved. We have suggested that a list of valid nominees is collated by the ICB and sent to all nominating organisations, and these should be asked to agree or reject the list as a whole. If this process is adopted, no response should be counted as agreement to address the risk of any eligible organisations not responding and delaying the process. Rejection or agreement applies to the whole list rather than a single nomination. If there are more agreements than rejections, the list should pass to the next stage.
 - The arrangement for generating 'joint nominations' should not in effect result in the veto or cancellation of an eligible organisation's valid nomination. If a nomination is not supported by the other eligible nominating organisations, there are two recommended options:
 - a) the nomination is withdrawn from the list voluntarily by the nominating organisation
 - or
 - b) the whole list of nominees is rejected, and the process restarted.
 - Reference to the appointment process being published in the Governance Handbook (or elsewhere) only is not acceptable.
 - The assessment, selection and appointment part of the process must be undertaken by the ICB; it may not be outsourced, for example to a collaborative or to a local representative committee. However, there would be no reason why an ICB could not choose to invite individuals from such bodies to provide advice to a suitably balanced ICB panel.
 - The assessment should be made against a person specification that is published in advance and which includes all the criteria for board membership, the specific role and disqualification criteria.

⁴⁰ ICBs need to specify the term and, if limited, the number of terms permitted (for the partner members it is not a requirement to limit the number of terms). The details of a re-appointment process should be specified, including at what intervals. Appointments are always to be subject to the approval of the chair.

⁴¹ Any holder of a contract for core primary care services with a list of registered patients (that is part of the ICB registered population) is expected to be eligible to take part in the nomination process.

⁴² The list of primary medical services providers that nominate the partner member for primary care should be published as part of the Governance Handbook, which does not form part of the Constitution. This is so updates to the list, which may be frequent, do not require NHS England approval to change the Constitution.

⁴³ For example, ICBs might refer to the nature of services provided or to the proportion of their services that are provided within the ICB area. Some ICBs have asked if they may appoint clinicians from other primary care professions (such as dentists, pharmacists and optometrists) to these roles. An ICB may appoint an individual who is not a GP, but the requirement for relevant primary medical services providers (contract holders with a list) to make the nominations must be complied with.

⁴⁴ The Constitution should set out who appoints the ordinary members. All appointments to the board of the ICB (except the chief executive) must by law be subject to the approval of the chair.

⁴⁵ Green font is used to recognise that councillors may be nominated, although it is expected it will normally be a senior local authority executive.

⁴⁶ The Constitution should set out who appoints the ordinary members. All appointments to the board of the ICB must by law be subject to the approval of the chair.

⁴⁷ ICBs need to specify the term and, if limited, the number of terms permitted (for the partner members it is not a requirement to limit the number of terms). The details of a re-appointment process should be specified including at what intervals. Appointments are always to be subject to the approval of the chair.

⁴⁸ NHS England guidance, to which this model constitution and notes are an annex, is that the board should normally include this role but recognise the role may be fulfilled in different ways, for example, they may have a different job title or hold other responsibilities with a wider portfolio.

⁴⁹ This does not exclude them from also being an employee of another organisation.

⁵⁰ NHS England guidance is that the board should include this role but recognise the role may be fulfilled in different ways; for example, they may have a different job title or hold other responsibilities with a wider portfolio.⁵¹⁵⁰ This does not exclude them from also being an employee of another organisation.

⁵¹ NHS England guidance, to which this model constitution and notes are an annex, is that the board must include this role but recognise the role may be fulfilled in different ways; for example, they may have a different job title or hold other responsibilities with a wider portfolio.

⁵² NHS England guidance, to which this model constitution and notes are an annex, is that the board must include this role but recognise the role may be fulfilled in different ways; for example, they may have a different job title or hold other responsibilities with a wider portfolio.

⁵³ This does not exclude them from also being an employee of another organisation.

⁵⁴ This guidance requires a minimum of 2 non-executive members (in addition to the chair). ICBs may choose if they wish to appoint more than 2 non-executive members. The locally agreed number should be inserted into clause 3.12.1.

⁵⁵ It is a requirement that the Constitution sets out who appoints the ordinary members. All appointments to the board of the ICB must by law be subject to the approval of the chair.

⁵⁶ The ICB may want to add other local criteria such as requiring non-executive members to have a connection to (such as living or working in) the ICB area. This is entirely for local determination.

⁵⁷ ICBs need to specify the term and number of terms permitted. Consistent with the Code of Governance for NHS trusts, non-executive members should not remain in post beyond 9 years from the date of their first appointment to the board and any decision to extend a term beyond 6 years should be subject to rigorous review. ICBs should also consider whether individuals who have served in equivalent roles on the boards of previous and current NHS bodies locally could be sufficiently independent.

⁵⁸ This is optional. The ICB can adopt this clause if they want to reduce the risk of lost continuity from mass retirement of board members.

⁵⁹ Any re-appointment process should be set out along with any associated criteria.

⁶⁰ There is a requirement that all the details of board appointments should be set out in the Constitution. For any additional roles (this does not include observers and participants), full details should be included as per the required roles.

⁶¹ The Constitution should set out what criteria are to be used. They are for local determination. The following are provided as suggestions:

- a) If they fail to attend a minimum of xx% of the meetings to which they are invited unless agreed with the chair in extenuating circumstances.
- b) If they are deemed to not meet the expected standards of performance at their annual appraisal.
- c) If they have behaved in a manner or exhibited conduct that 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:
 - dishonesty
 - misrepresentation (either knowingly or fraudulently)
 - defamation of any member of the ICBs (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
- d) Are deemed to have failed to uphold the Nolan Principles of Public Life.
- e) Are subject to disciplinary proceedings by a regulator or professional body.

⁶² Remuneration for board members not employed (such as the partner members) by the ICB is for the board to determine; but the ICB should ensure that no-one will be paid twice for the same time. Non-executive member remuneration cannot be determined by the remuneration committee if this committee's membership is entirely non-executive members of the board. ICBs could consider 2 options:

- establishing a separate remuneration panel for non-executive member remuneration
- adding further members to the remuneration committee such that the conflicted individuals could recuse themselves appropriately

The reference to non-executive members is in green text, to facilitate ICBs establishing remuneration committees that can be quorate without non-executive members when their remuneration is being discussed if this is what is determined locally.

⁶³ This is not a legal requirement, but if an ICB has developed such a code it could be referenced here.

⁶⁴ Please note committees and sub-committees may include, or be formed from, individuals who are neither employees nor board members of the ICB. This is one of the flexibilities that will enable ICBs to exercise their functions in a collaborative way with a wide range of partners from the ICB area.

⁶⁵ Terms of reference for committees will always be agreed by the board. Terms of reference for committees should specify whether or not the board is delegating the power to make further delegations to sub-committees and approve their terms of reference.

It is a requirement of the Act that members of committees and sub-committees that exercise the ICB commissioning functions are to be appointed or approved by the chair and the chair is prohibited from doing this if they consider that appointment could reasonably be regarded to undermine the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

If this became true for an existing member of the board, committee or sub-committee, they would be disqualified and so their appointment would end.

⁶⁶ ICBs should describe their own local arrangements. This might include requiring regular decision or assurance reports from committees to be submitted to the board, requiring attendance at board meetings of the chair, compliance with internal audit findings and committee effectiveness reviews.

All terms of reference should set out the arrangements for meetings and these will usually be in line with the standing orders or specified alternative arrangements. Best practice is that terms of reference should always be approved by the board (or by the parent committee for sub-committees when the board has delegated the power to establish sub-committees) and must always be aligned with the SoRD. Membership of committees should be specified by the board.

⁶⁷ Model audit committee terms of reference have been provided. The audit committee should be made up of independent people; this may include the non-executive members but not the chair. Not all members of the audit committee should be members of the board of the ICB. The chair of the audit committee should be independent, and it is not good practice for them to chair any other committees.

⁶⁸ Model terms of reference have been provided. The remuneration committee should be chaired by a non-executive member other than the audit committee chair. No individual should ever be involved in discussions about their own remuneration and the terms of reference should set out arrangements for ensuring this. The committee should be required to consider advice from a suitably qualified individual (such as a

director of HR or equivalent) and to ensure that suitable benchmarking informs their decisions.

⁶⁹ ICBs are not required to include the terms of reference in the Constitution (as previous organisations have been required to), but they must be published.

⁷⁰ ICBs are not required to include the terms of reference for all committees and sub-committees in the constitution but must publish them as part of their duty to be transparent. This also forms part of specifying the arrangement for exercising the functions.

⁷¹ Example contents could include:

- a) reporting arrangements to the board, at appropriate intervals, engagement events or other review sessions to consider the aims, objectives, strategy and progress of the arrangements
- b) progress reporting against identified objectives
- c) specify the legal basis for such arrangements
- d) identify the roles and responsibilities of all organisations that have agreed to work together
- e) specify how performance will be monitored and assurance provided to the board on the discharge of responsibilities, to enable appropriate oversight as to how strategic intentions are being implemented
- f) set out any financial arrangements that have been agreed, including identifying any pooled budgets (if applicable) and how these will be managed and reported in annual accounts
- g) specify how risks will be managed and apportioned between the respective parties
- h) set out how contributions from the parties, including details around assets, employees and equipment to be used, will be agreed and managed
- i) identify how disputes will be resolved and the steps required to safely terminate the working arrangements
- j) specify how decisions are communicated between the partners

⁷² While the ICB is no longer responsible for the direct exercise of the function and is not liable for errors made by the body to which the function is delegated, to act lawfully when deciding to delegate, an ICB would need to show that its decision was reasonable and complied with the other usual public law duties, such as the public sector equality duty, etc.

That is likely to involve carrying out due diligence, having a clear idea of what the benefits are of delegating the function and documenting the arrangements in a delegation agreement. It is also likely to involve some sort of monitoring of outcomes.

⁷³ The Constitution must specify arrangements for the exercise of the ICB's functions and the procedure for making decisions and for delegation. This is ordinarily set out in the standing orders. Any ICB that proposes not to include their full standing orders will be required to include other clauses that satisfy the full requirements of paragraphs 10 and 11 of schedule 1B to the 2006 Act.

⁷⁴ In line with the practice adopted by ICBs to date, the standing orders are expected to form part of the Constitution rather than be set out as separate document.

⁷⁵ Please see the NHS-wide guidance on conflicts of interest <https://www.england.nhs.uk/ourwork/coi/>. These set out minimum good practice for all NHS trusts, ICBs and NHS England.

⁷⁶ Where independent providers (including the voluntary sector) hold contracts for services (for example, community services), it would be appropriate and reasonable for the body to involve them in discussions (for example, about pathway design and service delivery, particularly at place level). However, this would be clearly distinct from any considerations around contracting and commissioning, from which they would be excluded.

⁷⁷ ICBs are legally required to publish the registers of interest or ensure that members of the public have access on request. (See section 14Z30(2) of the Act).

⁷⁸ The ICB should insert the names of their relevant policies.

⁷⁹ This is optional – ICBs are not required to appoint a conflict of interests guardian but may choose to do so as it is considered good practice. If an ICB does not appoint a conflict of interests guardian, this clause should be removed.

⁸⁰ The Act includes a requirement that ICBs include in their Constitution a statement of the principles to be followed in implementing the arrangements that have been made for conflicts of interest. Suggested principles are described in the guidance.

⁸¹ Section 14Z30 requires that ICBs maintain one or more registers of interest in relation to these categories of individuals.

⁸² ICBs are legally required to publish the registers of interest. It is good practice to ensure that members of the public have access on request.

⁸³ These clauses are not a strict legal requirement for inclusion in the Constitution but they are recommended as good practice in order to satisfy the Bribery Act 2010, which requires organisations to put in place appropriate procedures to prevent an 'associated person' from committing a number of offences including:

- offering, promising or giving a bribe
- requesting, agreeing to receive or accept a bribe
- bribing a foreign public official
- failure of a relevant commercial organisation to prevent bribery (the 'corporate offence').

⁸⁴ The ICB may want to include a set of transparency principles.

⁸⁵ The ICB is subject to the Public Bodies (Admission to Meetings) Act 1960. This has several associated requirements that ICB governance leads will wish to familiarise themselves with. The legal requirements apply to board meetings or committees at which all board members are present, or which are made up of only board members.

A body/committee that usually meets in public may, if it passes a resolution, exclude the public from all or part of a meeting if the item is of a confidential nature or for other special reasons stated in the resolution.

There is no expectation that remuneration or audit committees need be held in public.

⁸⁶ The Act makes it a legal requirement that ICBs publish registers of interests or make them available to the public on request.

⁸⁷ Some ICBs may have more than one Health and Wellbeing Board. The ICB is required to have regard to the local Health and Wellbeing Strategy under section 116B (1) of the Local Government and Public Involvement in Health Act.

⁸⁸ ICBs will need to ensure that there are decision-making structures within the ICB that will allow for decisions around arranging healthcare services to be made in line with the NHS Provider Selection Regime. This includes ensuring that there are appropriate governance structures that will deal with any challenges that may follow decisions about provider selection. ICBs will need to evidence that they have properly exercised their responsibilities for arranging healthcare services set out in the NHS Provider Selection Regime.

⁸⁹ Local titles may be used: for example, remuneration and HR or remuneration and nominations. Terms of reference do not need to be included but should be published.

⁹⁰ These should be locally determined; and might 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) any other relevant duties

⁹¹ The Act includes a requirement for a statement of principles to be followed by the ICB in implementing its arrangements regarding public involvement to be included in the Constitution. The 10 principles are from ICS implementation guidance on working with people and communities. Each ICB should use these principles as a basis for developing a system-wide strategy for engaging with people and communities,

building on the existing relationships, good practice and networks across system partners.

⁹² The ICB may want to add any further local principles.

⁹³ NHS England policy expectations are set out in ICS implementation guidance on working with people and communities.

⁹⁴ Likely to include local policies and procedures, and any commitments to regular events or structures for engagement.

⁹⁵ ICBs should edit the text provided to ensure that:

- a) there is consistency with local language (for example, for the names used for the meetings and roles)
- b) local agreements regarding, for example, quorum arrangements and voting arrangements are reflected
- c) there is clarity and no room for ambiguity

⁹⁶ It is not an explicit legal requirement to include the standing orders in the Constitution but it is a legal requirement to include the procedure to be followed for making decisions. The drafting of the model constitution template assumes that the procedure will be set out in the standing orders and that they are appended to the constitution. ICBs that choose not to append the standing orders must include additional information in their Constitution, beyond that indicated in the model.

⁹⁷ ICBs have incorporated the standing orders into their Constitution document so this is not required. If the ICB proposes to publish the standing orders as a separate document, the date from which they are effective should be added and kept up to date. The effective date is the date of approval by NHS England.

⁹⁸ It is good practice for a schedule of meetings to be agreed at the start of the year and to be supported by a cycle of business that sets out which recurring matters are handled at specific meetings throughout the year.

⁹⁹ The ICB should publish the times and places for the meetings.

¹⁰⁰ The experience of managing COVID-19 has shown that it is possible to convene virtual meetings with very short notice.

¹⁰¹ It is good practice for the agenda to be agreed by the chair in discussion with the lead executive director.

¹⁰² ICBs will need to have a policy and process for managing petitions and this should be published, but the ICB may choose to include this in the Governance Handbook rather than in the Constitution itself. There is no legal or policy guidance and ICBs are free to determine locally the content of their policy and procedures subject to compliance with other wider requirements.

¹⁰³ There is no requirement to allow deputies. The ICB can consider whether deputies will be allowed, for which roles, whether to permit them to vote or count

towards the quorum. Both ICBs and their board members should understand the accountabilities and liabilities associated with the role may not be delegated to a deputy. That means that there is accountability of the office holder, not the deputy.

The nature of the unitary board means that there are potential implications for all board members when other members delegate to a deputy. Ideally deputies should be named in advance and the deputy role should be included in their role description. Eligibility/ disqualification should also be confirmed.

Another option could be to allow the substantive office holder to confirm their nomination of a deputy in writing to the chair in advance of the meeting. This confirmation should also provide assurance to the chair that the nominated individual fulfils the requirements of the role and is not disqualified. Ad-hoc deputy arrangements should not normally be permitted.

If an ICB agrees to allow deputies, the following advice will be helpful:

- deputy arrangements must be set out in the standing orders
- it should be made clear which roles may appoint deputies
- members of the board or committee should understand the risks and associated liabilities
- mechanisms should be in place to ensure that any deputy is appropriately experienced, fulfils all requirements for the role and it has been confirmed that they are not disqualified

¹⁰⁴ ICBs will want to use the learning of COVID-19 to describe how individuals may attend meetings using technology solutions such as telephone and video attendance. Provision may be made for circumstances, where whole meetings may take place online. Consideration should be given to whether a minimum number should be physically present, under what circumstances virtual attendance will be permitted and arrangements for transparency, including the requirement for the meeting to be held in public.

¹⁰⁵ ICBs will want to consider the balance of perspectives required for good decision-making. This is likely to include a specified number of executive directors, a clinical perspective, an independent perspective and partner perspective.

¹⁰⁶ This ensures that the acts and decisions of the body are valid even if there are some vacancies or one of the members has been defectively appointed – this ensures that the body (or its board) does not need to be fully constituted to operate lawfully. It does not, however, allow an ICB to choose not to recruit to a vacancy; it merely affords time for the ICB to address a vacancy or defective appointment. Quorum requirements would still apply despite this clause.

¹⁰⁷ The standing orders need to be unambiguous about who is eligible to vote. Proxy could be permitted if the ICB chooses, and in such circumstances the full procedures for proxy voting must be specified.

¹⁰⁸ Not all ICBs will have these.

¹⁰⁹ ICBs may want to add something about consultation with other board members. A balance will be needed between allowing urgent decisions in exceptional circumstances and consulting other board members.