NHS
South East London

NHS South East London Integrated Care Board

CONSTITUTION

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1. Introduction

1.1 Background/ Foreword

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.

The South East London Integrated Care System is a partnership bringing together health and care organisations across the NHS, local authorities and the voluntary and independent sectors to best serve our population of almost two million residents in diverse communities. Our ambition is to deliver significant improvements in health and wellbeing in south east London, in particular through preventing ill health, delivering whole person care close to people's homes, joining up care across health and other public services, and tackling inequalities in access to care, experience and outcomes across our communities. We also want to make a major contribution to people's lives by supporting environmental sustainability and the economic and social resilience of our communities.

We are convinced that the best way of delivering these objectives is through partnership working and empowering people throughout our system to deliver change. This Constitution provides the foundation for a collective model of leadership and governance, bringing together leaders from across our system to decide how we use our resources, how we plan services, and how we oversee performance. It also provides a foundation for groups of staff within our system to take greater responsibility for how they manage local services, without needing to seek approval from others.

As part of these new arrangements, we will bring together senior leaders from across our system as part of an 'Integrated Care Partnership' to help set direction and oversee the system. The partnership will comprise leaders from public healthcare organisations, our local authorities, the voluntary, community and social enterprise sector and local Healthwatch branches who champion the interests of patients and the public in south east London. It will have responsibility for

developing an ‘integrated care strategy’ setting direction for health and care services in south east London. As well as setting this strategy, we envisage the partnership playing a key role in holding the leadership of south east London, including health and care organisations, collectively to account for delivering the strategy. We also envisage the partnership playing a key role in facilitating joint action across public services to improve health and care, address inequalities, influence the wider determinants of health and support social and economic development.

As well as the partnership, we will establish the unitary board needed for the statutory Integrated Care Board by bringing together senior leaders from health and care organisations. This will have formal responsibility for allocating resources for health and care within south east London and the planning and oversight of services. The board will be responsible for developing a plan to meet the needs of our population, targeting resources to deliver the plan, and contracting for delivery of services. It will also have key responsibilities for delivering our priorities for supporting our workforce, leading action to develop our digital and data capabilities and infrastructure and supporting the development of our estate amongst other priorities.

Whilst the board will play a central role in planning for our system, we believe in the importance of subsidiarity and will, wherever possible delegate responsibilities for organising services to partnerships within our system subject to appropriate governance and leadership arrangements being in place. In particular, it will delegate the budgets and responsibilities for out of hospital care to six local care partnerships in each borough, bringing together local health and care leaders, the voluntary, community and social enterprise sector and representatives of patients and the public for each of our boroughs. These local care partnerships will work collectively to design and deliver more effective local services, harnessing the strengths of different local organisations and restructuring services to better meet people’s needs.

The Board also plans to delegate budgets and responsibilities for some more services to provider collaboratives, groups of healthcare organisations within our system, where there are benefits in these organisations working together to better use their resources or to improve how care is delivered. All of these new partnerships, and individual organisations within our system, will have collective responsibility for improving services as well as meeting the statutory expectations which go with this delegation.

We are ambitious and committed to our aim of demonstrably improving the health and care of our residents. We believe that success will depend on harnessing the knowledge and commitment of clinical and care professionals as well as other leaders throughout our system, so that staff can bring all their creativity and energy to improving care. We are investing to ensure that clinical and care professional leaders in our system can spend time away from direct patient care supporting the types of improvement to services that will deliver lasting benefit for our

communities. We are also investing to give staff the leadership skills and knowledge of quality improvement, innovation and joint working with the public needed to deliver these roles.

Finally, we believe that success will depend on the strength of the partnership between health and care services in south east London and our communities. We want to involve our communities as actively as possible in our system, from the strategic oversight of the system to the design of services and to harness the power of our communities in supporting health and wellbeing. As part of these new arrangements, we are strengthening the role of citizens in the oversight of our system and creating the basis for citizens to work alongside clinical and care professionals in the planning and oversight of services, so we harness the insights of service users as a driver for innovation and improvement.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS South East London Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is south east London which includes the London Boroughs of Bexley, Bromley, Lambeth, Lewisham and Southwark and the Royal Borough of Greenwich.

1.4 Statutory Framework

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

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

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

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a Constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its Constitution (section 14Z29). This Constitution is published at www.selondonics.org/icb

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006

Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act)
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act)
c) Duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014)
d) Adult safeguarding and carers (the Care Act 2014)
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35); and
f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000)
g) Provisions of the Civil Contingencies Act 2004

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

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

a) section 14Z34 (improvement in quality of services)
b) section 14Z35 (reducing inequalities)
c) section 14Z38 (obtaining appropriate advice)
d) section 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 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022, 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 procedure and that application is approved; and
b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

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

a) Any ICB board member can propose a change to the Constitution. This needs to be in writing to the ICB's chair or chief executive who will pass proposed changes to the ICB's governance team.
b) The ICB's governance team will advise the chair and chief executive on the reasonableness of proposed changes for consideration by the board for rejection or acceptance.
c) Following board acceptance of any changes the amended constitution will be presented to NHS England for approval.
d) Proposed amendments to this constitution will not be implemented until an application to NHS England for variation has been approved

1.7 Related Documents

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

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

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

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

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

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

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

d) **The ICB Governance Handbook** - This brings together all the ICB's governance documents, so it is easy for interested people to navigate. It includes:
   - The above documents a) – c)
   - Terms of reference for all committees and sub-committees of the board that exercise ICB functions
   - Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act
   - Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act
   - The up-to-date list of eligible providers of primary medical services under clause 3.7.2

e) **Key policy documents** which should also be included in the Governance Handbook or linked to it **–** including:
   - Standards of Business Conduct Policy (which includes the ICB's Conflicts of Interest Policy)
   - SEL ICS Working with People and Communities Strategic Framework Public Information Access Policy
   - Petitions Policy
   - Records Management Policy
   - Persistent and Unreasonable Contacts Policy
   - NHS Records Management Code of Practice 2021

- Anti-fraud, Bribery and Corruption Policy

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.selondonics.org/icb.

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 Policy, requires the ICB to appoint the following additional Ordinary Members:

a) three executive members, namely:
   - Chief Financial Officer
   - Medical Director
   - Chief Nursing Officer
b) At least two non-executive members.

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

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

Whilst 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 five Partner Members as follows:

a) Partner Member NHS Trusts and Foundation Trusts X three
b) Partner Member Local Authorities
c) Partner Member Providers of Primary Medical Services

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

a) Chief Commissioning Officer
b) Two non-executive members

2.2.3 The board is therefore composed of the following members:

a) Chair
b) Chief Executive
c) Three Partner members NHS and Foundation Trusts
d) One Partner member Primary medical services
e) One Partner member Local Authorities
f) FourNon-executive members (one of which, but not the Audit Committee Chair, will be appointed Deputy Chair; and one of which, who may be the Deputy Chair or the Audit Committee Chair, will be appointed the Senior Non-Executive Member)
g) Chief Finance & Compliance Officer
h) Medical Director
i) Chief Nurse & Quality Officer
j) Chief Commissioning 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.

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 to effectively 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 Meetings

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.

2.3.2 Participants will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the chair. Any such person may be

invited, at the discretion of the chair to ask questions and address the meeting but may not vote.

2.3.3 Observers will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the chair. Any such person may not address the meeting and may not vote.

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"
b) Be committed to upholding the Seven Principles of Public Life (known as the Nolan Principles)
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification Criteria for Board Membership

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.

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

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

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

a) The Chair will be independent

3.3.3 Individuals will not be eligible if:

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

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

3.4 Deputy Chair and Senior Non-Executive Member

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 Member is to be appointed from 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

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

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

3.5.4 Individuals will not be eligible if

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

b) Subject to clause 3.5.3(a), they hold any other employment or executive role

3.6 Three X Partner Members – NHS Trusts and Foundation trusts

3.6.1 These Partner Members are jointly nominated by the NHS Trusts and/or Foundation Trusts which provide services for the purposes 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 Condition. Those organisations are:

a) Guy's & St Thomas' NHS Foundation Trust
b) King's College Hospital NHS Foundation Trust
c) Lewisham & Greenwich NHS Trust
d) South London & Maudsley NHS Foundation Trust
e) Oxleas NHS Foundation Trust
f) London Ambulance Service

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

a) Be a Chief Executive of one of the NHS Trusts or Foundation Trusts within the South East London ICB's area, listed at 3.5.1
b) They will bring perspectives across acute and emergency, mental health and community health services.
c) One of these partner members will have sufficient knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness to meet the requirement of paragraph 2.2.4.

3.6.3 Individuals will not be eligible if

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

3.6.4 These members will be appointed by the ICB selection panel, subject to the approval of the Chair, following the appointment process detailed in section 3.6.5.

3.6.5 The appointment process will be as follows:

a) The ICB will create role descriptions for the Partner Members – NHS trusts / foundation trusts, which will set out the requirements associated with the roles, the expected skills, knowledge and expertise that is necessary, and the term of office.

Nomination process

b) The ICB will issue the role descriptions to the partners identified in section 3.6.1, together with a timeline for a nomination and selection process.

c) All eligible organisations, listed at 3.6.1, are invited to make their individual or shared nominations, for the partner members - NHS trusts and foundation trusts from the eligible partners listed at 3.6.1, to the ICB chair. The nominations should be accompanied by a brief statement setting out how the candidate meets the requirements of the job role.

d) Eligible organisations will be asked to confirm their joint agreement to the full list of nominees, to be formally proposed to the ICB; this constitutes jointly nominating all of the nominees for consideration for appointment by the ICB and chair. All nominating organisations will be contacted and asked whether they support the list of nominations to be submitted, with nil replies being counted as agreement; a simple majority of eligible partners supporting the list will be sufficient to submit it to the ICB for selection.

e) If agreement cannot be reached the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

Selection process

f) Joint nominations will be considered by members of the selection panel to assess them against the criteria set out in the person specification and eligibility and disqualification criteria (clauses 3.6.2 and 3.6.3).

g) The ICB board will arrange a selection panel, who will assess the suitability against the criteria set, including the use of interviews as deemed appropriate, of each of the jointly nominated candidates for the partner member roles. This panel will be supported by a HR professional.

h) The ICB board selection panel will select the most suitable candidate for each role.

i) The chair of the ICB will determine whether to approve the appointment of the partner members.

j) The chair of the ICB will report the appointed partner members to the next meeting of the ICB board.

3.5.6 The term of office for these Partner Members will be three years. Individuals may serve a maximum of two terms. After a period of three years has passed since the end of their last term, an individual will become re-eligible for appointment. At the end of each term or should the selected member leave their Chief Executive role, or otherwise become ineligible for the partner member role, a new nomination and selection process will take place.

3.7 Partner Member - Providers of Primary Medical Services

3.7.1 This Partner Member is jointly nominated by providers of primary medical services for the purposes of the health service within the integrated care board's area, and that are primary medical services contract holders

responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility

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

3.7.3 This member must fulfil the eligibility criteria set out at 3.1 and will be selected from primary care providers within the South East London ICB area

3.7.4 Individuals will not be eligible if:

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

3.7.5 This member will be appointed by the ICB Board selection panel, subject to the approval of the Chair, following the appointment process detailed in section 3.7.6.

3.7.6 The appointment process will be as follows:

a) The ICB will create a role description for the Partner Member – Providers of primary medical services, which will set out the requirements associated with the roles, the expected skills, knowledge and expertise that is necessary, and the term of office.

Nomination process

b) The ICB will issue the role descriptions to all holders of a contract for core primary care services, who also hold a list of registered patients with a timeline for a nomination and selection process.

c) All eligible bodies are invited to make their individual or shared nominations to the ICB chair. This will be limited to one nomination per eligible body, which must be seconded by at least one other eligible body. Each nomination should be accompanied by a brief statement setting out how the candidate meets the requirements of the job role.

d) Eligible bodies will be asked to confirm their joint agreement to the full list of nominees, to be formally proposed to the ICB; this constitutes jointly nominating <u>all</u> nominees for consideration for appointment by the ICB and chair. All nominating bodies will be contacted and asked whether they support the list of nominations to be submitted, with nil replies being counted as agreement; a simple majority of eligible bodies supporting the list will be sufficient to submit it to the ICB for selection.

e) If agreement cannot be reached the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

Selection process

f) Jointly nominated candidates will be shortlisted, by members of the selection panel, against the skills, knowledge and experience required to fulfil the role and eligibility and disqualification criteria (clauses 3.7.3 and 3.7.4).

g) The ICB board will arrange a selection panel, who will assess the suitability, including the use of interviews as deemed appropriate, of each of the shortlisted candidates for the partner member role. This panel will be supported by a HR professional.

h) The ICB board selection panel will select the most suitable candidate for the role.

i) The chair of the ICB will determine whether to approve the appointment of the partner member.

j) The chair of the ICB will report the appointed partner member(s) to the next meeting of the ICB board.

3.7.7 The term of office for this Partner Member will be three years. Individuals may serve a maximum of two terms. After a period of three years has passed since the end of their last term, an individual will become re-eligible for appointment. At the end of each term a new nomination and selection process will take place.

3.7.8 Should the selected member leave their role, within primary care, or step down prior to the completion of their term, or otherwise become ineligible for the role, a new nomination and selection process will take place.

3.8 Partner Member - Local Authorities

3.8.1 This partner member is jointly 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) London Borough of Bexley
b) London Borough of Bromley
c) Royal Borough of Greenwich
d) London Borough of Lambeth
e) London Borough of Lewisham
f) London Borough of Southwark

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

g) Be a Chief Executive, hold a relevant executive level role or be a cabinet member of one of the local authorities within the South East London ICB's area, listed at 3.8.1

3.8.3 Individuals will not be eligible if

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

3.8.4 This member will be appointed by the ICB Board selection panel, subject to the approval of the Chair, following the appointment process detailed in section 3.8.5.

3.8.5 The appointment process will be as follows:

a) The ICB will create a role description for the Partner Member – Local Authorities, which will set out the requirements associated with the role, the expected skills, knowledge and expertise that is necessary, and the term of office.

Nomination process

b) The ICB will issue the role description to the partners identified in section 3.8.1, together with a timeline for a nomination and selection process.

c) All eligible organisations, listed at 3.8.1, are invited to make their individual or shared nominations, for the partner member – Local Authorities from the eligible partners listed at 3.8.1, to the ICB chair. The nominations should be accompanied by a brief statement setting out how the candidate meets the requirements of the job role.

d) Eligible organisations will be asked to confirm their joint agreement to the full list of nominees, to be formally proposed to the ICB; this constitutes jointly nominating all of the nominees for consideration for appointment by the ICB and chair. All nominating organisations will be contacted and asked whether they support the list of nominations to be submitted, with nil replies being counted as agreement; a simple majority of eligible partners supporting the list will be sufficient to submit it to the ICB for selection.

e) If agreement cannot be reached the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

Selection process

f) Joint nominations will be considered by a panel including the Chief Executive to assess the nominations against the criteria set out in the person specification and the eligibility and disqualification criteria (clauses 3.8.2 and 3.8.3).

g) The ICB board will arrange a selection panel, who will assess the suitability against the criteria set, including the use of interviews as deemed appropriate, of each of the jointly nominated candidates for the partner member role. This panel will be supported by a HR professional.

h) The ICB board selection panel will select the most suitable candidate for the role.

i) The chair of the ICB will determine whether to approve the appointment of the partner member.

j) The chair of the ICB will report the appointed partner member(s) to the next meeting of the ICB board.

3.8.6 The term of office for this Partner Member will be three years. Individuals may serve a maximum of two terms. After a period of three years has passed since the end of their last term, an individual will become re-eligible for appointment. At the end of each term or should the selected member leave their local authority role, or otherwise become ineligible, a new nomination and selection process will take place.

3.9 Medical Director

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

3.9.1.1 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

3.9.1.2 Be a registered Medical Practitioner

3.9.2 Individuals will not be eligible if:

3.9.2.1 Any of the disqualification criteria set out in 3.2 apply

3.9.3 This member will be appointed by the Chief Executive subject to the approval of the Chair.

3.10 Chief Nurse & Quality Officer

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

3.10.1.1 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

3.10.1.2 Be a registered Nurse

3.10.2 Individuals will not be eligible if:

3.10.2.1 Any of the disqualification criteria set out in 3.2 apply

3.10.3 This member will be appointed by the Chief Executive subject to the approval of the Chair.

3.11 Chief Finance & Compliance Officer

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

3.11.1.1 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

3.11.2 Individuals will not be eligible if:

3.11.2.1 Any of the disqualification criteria set out in 3.2 apply

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

3.12 Chief Commissioning Officer

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

3.12.1.1 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

3.12.2 Individuals will not be eligible if:

3.12.2.1 Any of the disqualification criteria set out in 3.2 apply

3.12.3 This member will be appointed by the Chief Executive subject to the approval of the Chair

3.13 Four Non-Executive Members

3.13.1 The ICB will appoint four Non-Executive Members

3.13.2 These members will be appointed by a panel including the ICB Chair

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

3.13.3.1 Not be an employee of the ICB or a person seconded to the ICB
3.13.3.2 Not hold a role in another health and care organisation in the ICS area
3.13.3.3 One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee
3.13.3.4 Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee

3.13.4 Individuals will not be eligible if

3.13.4.1 Any of the disqualification criteria set out in 3.2 apply

3.13.4.2 They hold a role in another health and care organisation within the ICB area

3.13.5 The term of office for a non-executive member will be three years and the total number of terms an individual may serve is two terms after which they will no longer be eligible for re-appointment.

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

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) 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) In the opinion of the Chair:

i. they fail to meet satisfactory performance standards in accordance with paragraph 3.1 of this Constitution

ii. they fail to attend a minimum of 75% of meetings to which they are invited unless agreed with the Chair in extenuating circumstances

iii. they are deemed to not meet the expected standards of performance at their annual appraisal

iv. 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

v. they are subject to disciplinary proceedings by a regulator or professional body

3.14.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 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.

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:

3.14.6.1 terminate the appointment of the ICB's Chief Executive; and
3.14.6.2 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 remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published at www.selondonics.org/icb 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 a committee comprising the five partner members and approved by the Chair.

3.15.2 Other terms of appointment, outside of the Constitution, 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.

4.2 General

4.2.1 The ICB will:

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

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with 4.2.1 (a)-(f), documenting them as necessary in this Constitution, its governance handbook and/or 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 (SoRD).

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full at www.selondonics.org/icb

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 at www.selondonics.org/icb

4.5.3 The map includes:

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

4.6 Committees and Sub-Committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

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

4.6.3 Each committee established by the ICB operates under terms of reference agreed by the board. Each sub-committee established by the ICB operates under terms of reference agreed by the committee to which it reports, as delegated by the board. 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. These include that the committee will report on its activities to the ICB Board via minutes. In addition, an accompanying report will summarise key points of discussion, items recommended for decisions, the key activities undertaken or coordinated by the committee and any actions agreed to be implemented. The minutes of meetings shall be formally recorded and reported to the ICB Board for the purposes of assurance and made publicly available as part of ICB meeting papers.

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 Chair. 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 Standing Financial Instructions (SFIs) and any other relevant ICB policy

4.6.8 The following committees will be maintained:

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

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

4.6.8.2 **Remuneration Committee:** This committee is accountable to the board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration Committee will be chaired by a Non-Executive member other than the Chair or the Chair of the Audit Committee.

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

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 published in the governance handbook.

4.7 Relationship between the Integrated Care Board, Integrated Care Partnership and Local Care Partnerships

4.7.1 Our Integrated care partnership will bring together leaders from across healthcare organisations, our local authorities and other partners to help set strategic direction and oversee the system, including developing an 'integrated care strategy' for health and care services. Our integrated care board will bring together senior leaders from health and care organisations and will have statutory responsibility for allocating resources for health and care within south east London and the planning and oversight of services. Groups of service providers in our system will work together in provider collaboratives to make better use of resources and improve how care is delivered. Local care partnerships within our six boroughs will be responsible for overseeing and improving out of hospital services.

4.8 Delegations made under section 65Z5 of the 2006 Act

4.8.1 As per 4.3.2 The ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.8.2 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.

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

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

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

5 Procedures for Making Decisions

5.1 Standing Orders

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

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

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

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and 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 is published at www.selondonics.org/icb

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

6.1 Conflicts of Interest

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

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest, as part of the Standards of Business Conduct policy, which is published on the website, www.selondonics.org/icb.

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, included within the Standards of Business Conduct policy, 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 and the Standards of Business Conduct Policy, which includes the ICB's Conflicts Of Interest Policy.

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

- 6.1.6.1 Act as a conduit for members of the
- 6.1.6.2 and members of the partnership who have any concerns with regards to conflicts of interest
- 6.1.6.3 Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest
- 6.1.6.4 Support the rigorous application of conflict of interest principles and policies

6.1.6.5 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

6.1.6.6 Provide advice on minimising the risks of conflicts of interest

6.2 Principles

6.2.1 In discharging its functions the ICB will abide by the principles included in the ICB's Standards of Business Conduct Policy as follows:

a) The 'Seven Principles of Public Life', also known as the Nolan principles

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

c) **Be proactive, not reactive:** Everyone within the scope of this policy should seek to identify and minimise the risk of conflicts of interest at the earliest possible opportunity

d) **Be balanced, sensible and proportionate**: Rules should be clear and robust but not overly prescriptive or restrictive. They should ensure that decision-making is transparent and fair whilst not being overly constraining, complex or cumbersome

e) **Be transparent:** Document clearly the approach and decisions taken at every stage of NHS activity so that a clear audit trail is evident

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

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

a) Members of the ICB
b) Members of the board's committees and sub-committees
c) Its employees

6.3.2 In accordance with section 14Z30(2) of the 2006 Act, registers of interest are published on the ICB website, www.selondonics.org/icb.

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

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing.

Interests will also be declared on appointment and during relevant discussion in meetings.

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

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

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

6.3.8 Activities funded in whole or in part by third parties who may have an interest in South East London 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 which includes the requirements 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 Meetings and publications

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

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

7.2.3 Annual accounts will be externally audited and published.

7.2.4 A clear complaints process will be published.

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

7.2.6 Information will be provided to NHS England as required.

7.2.7 The Constitution and governance handbook will be published as well as other key documents including but not limited to:

7.2.7.1 Standards of Business Conduct policy
7.2.7.2 Registers of interests
7.2.7.3 Key ICB policies

7.2.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years (the “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:
    - sections 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 joint local health and wellbeing strategies for the following:
    - London Borough of Bexley
    - London Borough of Bromley

- Royal Borough of Greenwich
- London Borough of Lambeth
- London Borough of Lewisham
- London Borough of Southwark

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 of children or adults).

7.3 Scrutiny and decision-making

7.3.1 At least four non-executive members will be appointed to the board including the Chair; and all of the board and committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

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

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

a) Ensuring that its planning and commissioning processes are compliant with the new PSR.

b) Ensuring that ICB policies reflect PSR requirements.

c) Providing training with planning, commissioning and finance teams to ensure a clear understanding of requirements.

d) Ensuring that governance is in place around the transparency of decision making, including the use of Local Care Partnerships for local commissioning decisions and the ICB Executive around south east London wide commissioning decisions

e) Ensuring that a contracts register is in place to enable oversight of the ICB's contract portfolio and the procurement pipeline, which will be overseen by the ICB's Planning and Delivery Group.

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

7.4 Annual Report

7.4.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. 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 Committee 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 ensures that the Remuneration Committee has access to appropriate advice by attendance of a senior HR representative from the ICB at meetings.

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 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 are detailed in its terms of reference, which can be found in the Governance Handbook, and include:

- Confirming the ICB Pay Policy including adoption of any pay frameworks, including Agenda for Change, for all employees including senior managers/directors (including board members)

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

a) the planning of the commissioning arrangements by the Integrated Care Board

b) the development and consideration of proposals by the ICB 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

c) 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 arrangements to consult and engage its population on its system plan as outlined in the SEL ICS working with people and communities strategy available on the ICS website.

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

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.

b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.

c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.

d) Build relationships with excluded groups – especially those affected by inequalities.

e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.

f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust.

g) Use community development approaches that empower people and communities, making connections to social action.

h) Use co-production, insight and engagement to achieve accountable health and care services.

i) Co-produce and redesign services and tackle system priorities in partnership with people and communities.

j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

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

9.5 These arrangements, include:

a) Outreach
b) Working with trusted voices in VCSE and faith organisations
c) Community champions
d) Citizens' Panel
e) Let's talk health and care in south east London engagement platform
f) Working with people with lived experience
g) Co-production

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
ICB Board	Members of the ICB
Area	The geographical area that the ICB has responsibility for, as defined in part 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.
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.
Local Care Partnership	Local Care 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	Provider Collaboratives are collaborative arrangements that take responsibility for the planning, delivery and improvement of services on an area basis where there is benefit in adopting a collaborative rather than a by provider approach. SEL has a provider collaborative for acute services (the Acute Provider Collaborative) and for mental health (the South London Partnership). Provider

	Collaboratives form part of the formal system architecture and governance of the Integrated Care Body and Integrated Care System
Primary Care Leadership Group	The primary care leadership group is a networked primary care collaborative which encourages sharing and learning across south east London to secure improved primary care services to meet the needs of its local community within a principle of equality for all. It provides a forum for engagement with a wide-ranging group of primary care leaders who are able to work with conflict and difference and provide clear direction to the system.
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	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following**:** • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description • the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description • the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
Chief Nurse & Quality Officer	This is NHS South East London ICB's name for the Director of Nursing. The Director of Nursing is a required additional ordinary member according to NHS England Policy

Chief Finance & ComplianceOfficer	This is NHS South East London ICB's name for the Director of Finance. The Director of Finance is a required additional ordinary member according to NHS England Policy
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

Appendix 2: Standing Orders

1. Introduction

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

2. Amendment and review

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

2.2. Amendments to these Standing Orders will be made as per clause 1.6 of the Constitution.

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

3. Interpretation, application and compliance

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

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

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

3.4. In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the ICB's governance department will provide a settled view which shall be final.

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

3.6. If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification and the Audit Committee for review.

4. Meetings of the Integrated Care Board

4.1. Calling Board Meetings

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

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

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

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

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

4.1.3. A public notice of the time and place of 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 in part of a meeting 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 stead.

4.2.3. If both the Chair and Deputy Chair are absent or disqualified from participating by a conflict of interest, the assembled members shall appoint a temporary Deputy, from the remaining non-conflicted Non-Executive Members, for the purpose of chairing the meeting.

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 Chair of the meeting.

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

4.3.3. Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at www.selondonics.org/icb.

4.4. Petitions

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

4.5.1. Board Members are expected to attend all Board meetings and as such deputies will not be permitted to attend on their behalf.

4.6. Virtual attendance at meetings

4.6.1. 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

4.7.1. The quorum for meetings of the Board will be at least 50% of members, rounded up to the next whole number member and must also include:

a) At least 3 executive members including the Medical Director or Chief Nurse & Quality Officer and Chief Executive or Chief Finance & Compliance Officer
b) At least 3 non-executive members
c) At least 1 partner member

4.7.2. Where a quorum cannot be convened from the membership of the meeting, including owing to the arrangements for managing conflicts of interest or potential conflicts of interest, the Chair of the meeting shall consult with the Board on the action to be taken. This may include (such a position shall be recorded in the minutes of the meeting):

a) deferring the discussion and/or the passing of a resolution. The meeting must then proceed to the next business item.
b) requiring another of the ICB's committees or sub-committees (as appropriate) to progress the item of business, or if this is not possible)
c) as a last resort, reducing the quorum to 40% of members but must include:
   i) At least 2 Executive members including the Medical Director or Chief Nurse & Quality Officer and the Chief Executive or Chief Finance & Compliance Officer ii) At least 2 Non-Executive members
   iii) At least 1 partner member

4.7.3. For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.
b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

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

4.8. Vacancies and defects in appointments

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

4.8.2. In the event of a vacancy or defect in appointment the quorum will remain as outlined in section 4.7 Quorum (i.e., there will be no reduction in the quoracy outlined in these standing orders).

4.9. Decision making

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

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

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

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

c) For the sake of clarity, any additional participants and observers will not have voting rights.

d) A resolution will be passed if more votes are cast for the resolution than against it, on condition that the votes cast for / against are not entirely executive votes.

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

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

<u>Disputes</u>

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

Urgent decisions

4.9.4. 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:

a) The powers which are reserved or delegated to the Board, may for an urgent decision be exercised by the ICB Chair or Chief Executive (or relevant Chair in the case of committees) subject to every effort having been made to consult with as many members as possible in the circumstances. This would usually include at least two other Board representatives, including at least one non-executive. In the case of committee Chairs this consultation should also include the Chair and / or Chief Executive.

b) These emergency action functions may be exercised by such other persons as the Chair and Chief Executive may respectively nominate in writing.

c) The exercise of such powers shall be reported to the next formal meeting of the Board for formal ratification and a log maintained for inspection by the audit committee.

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 the 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 regards to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the ICB'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 agreement 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 The ICB has a seal for executing documents where necessary. The seal shall be kept in safe custody by the Chief Executive Officer or a person appointed by the Chief Executive Officer.

6.2 The following individuals or officers can authenticate the seal's use by their signature. Two of the following are required to seal documents:

- The Chief Executive Officer
- The Chief Finance & Compliance Officer
- The Medical Director
- The Chief Nurse & Quality Officer