North East London
Integrated Care Board

NHS North East London Integrated Care Board

CONSTITUTION

Version	Effective Date
1.2	2 December 2022

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Introduction

1.1 Background

1.1.1 NHS England has set out the following as the four core purposes of Integrated Care Systems ("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.

1.1.2 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.

1.2 Name

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

1.3 Area Covered by the ICB

1.3.1 The Area covered by the ICB is coterminous with the administrative boundaries of the following local authorities:

a) City of London Corporation;

b) London Borough of Barking and Dagenham;

c) London Borough of Hackney;

d) London Borough of Havering;

e) London Borough of Newham;

f) London Borough of Redbridge;

g) London Borough of Tower Hamlets;

h) London Borough of Waltham Forest.

1.3.2 The Area described above is shown in the map below:

1.3.3 Within the Area, the ICB and the local authorities outlined above have also established a joint committee in accordance with section 116ZA of the Local Government and Public Involvement in Health Act 2007, to be known as the North East London Integrated Care Partnership and, together with other partner organisations, the ICB and the local authorities have formed a number of Place-Based Partnerships.

1.3.4 Terms of reference and more information about the Integrated Care Partnership, the Place-Based Partnerships and other governance structures established by the ICB and its partners can be found in the ICB Governance Handbook ("Handbook"). The Handbook and more information about the Integrated Care Partnership is available here: www.northeastlondonicb.nhs.uk and www.northeastlondonhcp.nhs.uk

1.4 Statutory Framework

1.4.1 The ICB is established by an 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.northeastlondonicb.nhs.uk

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both its 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 to 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 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 include, in particular, 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 This Constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.

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

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act, this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and

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

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

a) Proposed amendments to this Constitution may be submitted by the Chief Executive or other Executive Director for consideration and approval by the Board, prior to such amendments being submitted to NHS England;

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

1.7 Related Documents

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

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

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

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

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

b) **Functions and Decision Map** – 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 Handbook** – This brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:

(i) the above documents at a) to c);

(ii) terms of reference for all committees and sub-committees of the Board that exercise ICB functions;

(iii) delegation arrangements for all instances where ICB functions are delegated, including 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 body duly prescribed in secondary legislation; or to a joint committee of the ICB and one or more of those organisations in accordance with section 65Z6 of the 2006 Act;

(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 body duly prescribed in secondary legislation; or to a joint committee of the ICB and one or more of those organisations in accordance with section 65Z6 of the 2006 Act;

(v) the up-to-date list of relevant providers of primary medical services, referred to at clause 3.6.2 below;

(vi) the up-to-date list of 'umbrella/infrastructure' organisations working within the VCSE sector within the Area, referred to at clause 3.8.1 below;

(vii) other documents as determined by the Chief Executive, or director responsible for governance, for inclusion in the Handbook from time to time.

e) **Key policy documents** – These shall be included in the Handbook, or linked to it. They include the following, as amended, supplemented or updated from time to time by the Board:

(i) Standards of Business Conduct Policy;

(ii) Conflicts of interest policy and procedures;

(iii) Policy for public involvement and engagement, in the form of its Working with People and Communities Strategy.

Composition of the Board

2.1 Membership of the Board

2.1.1 This part of the Constitution describes the membership of the Board of the ICB (members of the ICB are referred to as "Board Members"). Further information about the criteria for the roles and how they are appointed is in section 3 below.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website at www.northeastlondonicb.nhs.uk.

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

2.1.4 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the Board consists of:

a) a Chair;

b) a Chief Executive;

c) at least three Ordinary Members.

2.1.5 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 and appointed in accordance with the procedures set out in Section 0 below. The Partner Members shall comprise:

a) two members nominated jointly by NHS trusts and foundation trusts who provide services for the purposes of the health service within the Area and are of a description prescribed in secondary legislation;

b) two members nominated jointly by persons who provide primary medical services for the purposes of the health service within the Area and are of a description prescribed in secondary legislation;

c) two members nominated jointly by the local authorities which are responsible for providing social care and whose areas coincide with, or include the whole or any part of, the 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.

2.1.6 Accordingly, the ICB has six Partner Members.

2.1.7 NHS England policy requires the ICB to appoint the following additional Ordinary Members:

a) three executive members, namely:

(i) A role fulfilling that of Medical Director;

(ii) Director of Finance, to be known by the ICB as the Chief Finance and Performance Officer;

(iii) Director of Nursing, to be known by the ICB as the Chief Nursing Officer.

b) at least two non-executive members.

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

a) an additional (i.e. third) non-executive member

b) a member, who brings knowledge and experience from the Voluntary, Community and Social Enterprise ("VCSE") sector, and will contribute the perspective of the VCSE sector to the decisions of the Board.

2.1.9 The Chair will exercise their function to approve the appointment of the Ordinary Members with a view to ensuring that at least one such member will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness. This will be achieved through the appointment of one of the Partner Members referred to at 2.1.5a), as described in section 3.5 below.

2.1.10 In accordance with its duty under section 14Z49 of the 2006 Act, 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 carry out its functions effectively, and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.1.11 The Board is therefore composed of the following 15 Board Members:

a) Chair;

b) Chief Executive;

c) two Partner Members (NHS trusts and foundation trusts);

d) two Partner Members (primary medical services);

e) two Partner Members (local authorities);

f) Chief Finance and Performance Officer;

g) The role fulfilling that of ICB Medical Director;

h) Chief Nursing Officer;

i) three non-executive members;

j) VCSE member.

2.2 Regular participants at Board Meetings

2.2.1 The Board may invite specified individuals to be participants at its meetings in order to inform its decision making and the discharge of its functions as it sees fit.

2.2.2 A list of participants who will receive standing invitations to meetings of the Board is contained in the Handbook. Participants will receive advance 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.

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

Appointments Process for the Board

3.1 Eligibility Criteria for Board Membership

3.1.1 Each Board Member must:

a) comply with the criteria of the “fit and proper person test”;

b) be willing to uphold the Seven Principles of Public Life (known as the “Nolan Principles”);

c) fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification Criteria for Board Membership

3.2.1 Individuals of the following descriptions are automatically disqualified from membership of the Board:

a) A Member of Parliament;

b) 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;

c) A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted:

(i) in the United Kingdom of any offence; or

(ii) 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;

d) 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);

e) 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;

f) 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:

(i) 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;

(ii) that the person failed, without reasonable cause, to attend any meeting of that Health Service Body for three successive meetings;

(iii) 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

(iv) of misbehaviour, misconduct or failure to carry out the person's duties;

g) A Health Care Professional 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:

(i) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated;

(ii) the person's erasure from such a register, where the person has not been restored to the register;

(iii) 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

(iv) 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;

h) A person who is subject to:

(i) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986

or the Company Directors Disqualification (Northern Ireland) Order 2002; or

(ii) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual);

i) 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;

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

(i) 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

(ii) 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).

3.2.2 Individuals' declared interests will be considered as part of the appointment process for Board Members to determine whether, in line with any guidance issued by NHS England or other relevant bodies, there are any conflicts that warrant individuals being excluded from appointment to the Board.

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England with the approval of the Secretary of State for Health and Social Care.

3.3.2 In addition to the eligibility criteria specified at 3.1, this member must be independent.

3.3.3 Individuals will not be eligible for this role if:

a) they hold a role in another health and care organisation which provides services within the Area;

b) any of the disqualification criteria set out in 3.2 apply.

3.3.4 Subject to NHS England's national policy and requirements and as set out in the letter of appointment to the role, the term of office for this role will be for three years in duration and the maximum number of terms which may be served is three.

3.4 Chief Executive

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

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

3.4.3 In addition to the eligibility criteria specified at 3.1, the Chief Executive must 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.

3.4.4 Individuals will not be eligible for this role if:

a) any of the disqualification criteria set out in 3.2 apply;

b) subject to clause 3.4.3, they hold any other employment or executive role.

3.5 Partner Members – NHS Trusts and Foundation Trusts

3.5.1 Two 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 Area and meet the Forward Plan Condition or (if the Forward Plan Condition is not met) the Level of Services Provided Condition:

a) Barking, Havering and Redbridge University Hospitals NHS Trust;

b) Barts Health NHS Trust;

c) East London NHS Foundation Trust;

d) Homerton University Hospital NHS Foundation Trust;

e) North East London NHS Foundation Trust;

f) London Ambulance Service NHS Trust.

3.5.2 These members must fulfil the eligibility criteria set out at 3.1 and also be an executive director of one of the NHS trusts or foundation trusts within the Area. One such member must have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness in order that the Chair can achieve the requirements of clause 2.1.9 above. Such knowledge and experience to be described further in the relevant role description.

3.5.3 Individuals will not be eligible for this role if any of the disqualification criteria set out in 3.2 apply.

3.5.4 These members will be appointed by the Chief Executive subject to the approval of the Chair.

3.5.5 The appointment process in respect of **each** role will be as follows:

a) Nomination

(i) When a vacancy arises, the ICB will create a role description, which will set out the expectations associated with the role (including the expected skills, knowledge, time commitment and term of office) and shall issue that role description to the partner organisations referred to at 3.5.1, together with an invitation to nominate, a timeline for the nomination and setting out any further information about the nomination and appointment process.

(ii) The nomination process will be managed by the partner organisations named at 3.5.1 above, with advice and support from the ICB's governance team as appropriate.

(iii) Those partner organisations participating in the nomination of candidates shall: (a) have regard to any guidance published by NHS England in relation to the selection of candidates; (b) ensure candidates who are nominated are eligible for the role in accordance with the criteria for eligibility and disqualification set out above; and (c) have due regard to the role description.

(iv) The aim of the nominations process shall be for the partner organisations to determine a jointly agreed individual or individuals to be put forward for appointment to each role. Accordingly, the partner organisations shall put forward to the Chief Executive a single agreed list of those they are putting forward to be considered for appointment under step b) below.

b) Appointment

(i) Appointment will be made as a result of a formal assessment by the Chief Executive (with the support of an ICB governance officer, as appropriate) against the expectations of the role description and the eligibility and disqualification criteria for Board membership as set out above, and to ensure the individual has the ability to contribute effectively to the overall functioning of the Board.

(ii) Should no individual be nominated, or no individual be eligible or determined as suitable for appointment following assessment, then the nominations and

appointment process described above shall be repeated.

(iii) Appointment to the role will always be subject to approval by the Chair.

3.5.6 The normal term of office for these roles will be three years in duration and in accordance with the letter of appointment to the role, following which the NHS trusts and foundation trusts referred to in 3.5.1 will be asked to nominate an individual in accordance with the process set out at 3.5.5 above. An individual will only be eligible for further nomination and reappointment if they continue to meet the relevant criteria outlined above.

3.5.7 Initial appointments may be for a shorter term (i.e. less than three years), in order to avoid all Ordinary Members retiring at once.

3.6 Partner Members – Providers of Primary Medical Services

3.6.1 These two Partner Members are both nominated jointly by providers of primary medical services for the purposes of the health service within the 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.

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

3.6.3 Such a Partner Member must fulfil the eligibility criteria set out at 3.1 above and also the following additional eligibility criteria. The member must:

a) not hold any other senior clinical leadership role in the ICB that would compromise the candidate's ability to carry out the role;

b) have sufficient senior experience at board level or experience leading collaborative programmes (for example, gained from working within an NHS or VCSE organisation or a local authority).

3.6.4 Individuals will not be eligible if any of the disqualification criteria set out in 3.2 apply.

3.6.5 Such a member will be appointed by the Primary Medical Services Partner Member Selection Panel ('the Panel'), subject to the approval of the Chair. The appointment process in respect of **each** role will be as follows:

a) Nomination

(i) When a vacancy arises, the ICB will create a role description, which will set out the expectations associated with the role (including the expected skills, knowledge, time commitment and term of office) and shall issue that role description to the eligible providers of primary medical services referred to at 3.6.1, together with an invitation to nominate, a timeline for the nomination and setting out any further information about the nomination and appointment process.

(ii) The nomination process will be managed by the ICB.

(iii) Those eligible providers of primary medical services participating in the nomination of candidates shall: (a) have regard to any guidance published by NHS England in relation to the selection of candidates; (b) ensure candidates who are nominated are eligible for the role in accordance with the criteria for eligibility and disqualification set out above; and (c) have due regard to the role description.

(iv) In respect of each vacancy, each eligible provider of primary medical services may choose one individual to be put forward for nomination. Each choice must be formally supported ("seconded") by another such eligible provider, in order to be entered on to the 'Primary Care Joint Nomination(s) List.' The individual(s) may be from the eligible provider of primary medical services' own organisation or from another eligible provider of primary medical services' organisation.

(v) The aim of the nomination process shall be for the eligible providers of primary medical services to determine a jointly agreed individual or individuals to be put forward for appointment to each role. Accordingly, the eligible providers of primary medical services shall confirm to the Panel whether or not they agree to the list being put forward to step b) below. A failure to confirm within a specified timeframe will be deemed to constitute agreement to the list.

(vi) If a simple majority of eligible providers of primary medical services does not, or is not deemed to, agree to the list being put forward, the process above will be re-run until the agreement of a simple majority of eligible providers of primary medical services to a list of nominees has been confirmed.

b) Appointment

(i) The Primary Care Joint Nomination(s) List will be considered by the Panel. Appointment will be made as a result of a formal assessment by the Panel against the expectations of the role description and the eligibility and disqualification criteria for Board membership as set out above, and to ensure the individual has the ability to contribute effectively to the overall functioning of the Board. Should this result in more than one individual being eligible and suitable for appointment to each role, then a subsequent interview process will take place.

(ii) Should no individual be eligible or determined as suitable for appointment following assessment, then the nominations and appointment process described above shall be repeated.

(iii) Appointment to the role will always be subject to approval by the Chair.

3.6.6 The normal term of office for these roles will be three years in duration and in accordance with the letter of appointment to the role, following which further nominations will be sought, and an appointment will be made, in accordance with the process set out at 3.6.5 above. An individual will only be eligible for further nomination and reappointment if they continue to meet the relevant criteria outlined above.

3.6.7 Initial appointments may be for a shorter term (i.e. less than three years), in order to avoid all Ordinary Members retiring at once.

3.7 Partner Members – local authorities

3.7.1 These two Partner Members are both nominated jointly by the local authorities whose areas coincide with or include the whole or any part of the Area. Those local authorities are set out at 1.3.1 above.

3.7.2 Such a Partner Member will fulfil the eligibility criteria set out at 3.1 and also be the Chief Executive, hold a relevant Executive-level role or be an elected member of one of the bodies referred to at 3.7.1.

3.7.3 Individuals will not be eligible if any of the disqualification criteria set out in 3.2 apply.

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

3.7.5 The appointment process in respect of **each** role will be as follows:

a) Nomination

(i) When a vacancy arises, the ICB will create a role description, which will set out the expectations

associated with the role (including the expected skills, knowledge, time commitment and term of office) and shall issue that role description to the partner organisations referred to at 3.7.1, together with an invitation to nominate, a timeline for the nomination and setting out any further information about the nomination and appointment process.

(ii) The nomination process will be managed by the partner organisations named at 3.7.1 above, with advice and support from the ICB's governance team as appropriate.

(iii) Those partner organisations participating in the nomination of candidates shall: (a) have regard to any guidance published by NHS England in relation to the selection of candidates; (b) ensure candidates who are nominated are eligible for the role in accordance with the criteria for eligibility and disqualification set out above; and (c) have due regard to the role description.

(iv) The aim of the nominations process shall be for the partner organisations to determine a jointly agreed individual or individuals to be put forward for appointment to each role. Accordingly, the partner organisations shall put forward to the Chief Executive a single agreed list of those they are putting forward to be considered for appointment under step b) below.

b) Appointment

(i) Appointment will be made as a result of a formal assessment by the Chief Executive (with the support of an ICB governance officer, as appropriate) against the expectations of the role description and the eligibility and disqualification criteria for Board membership as set out above and to ensure the individual has the ability to contribute effectively to the overall functioning of the Board.

(ii) Should no individual be nominated, or no individual be eligible or determined as suitable for appointment following assessment, then the nominations process described above shall be repeated.

(iii) Appointment to the role will always be subject to approval by the Chair.

3.7.6 The normal term of office for these roles will be three years in duration and in accordance with the letter of appointment to the role, following which the local authorities will be asked to nominate an individual in accordance with the process set out at 3.7.5 above. An individual will

only be eligible for further nomination and reappointment if they continue to meet the relevant criteria outlined above.

3.7.7 Initial appointments may be for a shorter term (i.e. less than three years), in order to avoid all Ordinary Members retiring at once.

3.8 Further Ordinary Member – VCSE

3.8.1 This Ordinary Member is drawn from 'umbrella/infrastructure' organisations working within the VCSE sector within the Area, which are listed within the Handbook.

3.8.2 This further Ordinary Member will:

a) fulfil the eligibility criteria set out at 3.1;

b) be a Chief Executive of one of the organisations referred to at 3.8.1.

3.8.3 Individuals will not be eligible if any of the disqualification criteria set out in 3.2 apply.

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

3.8.5 The appointment process in respect of this role will be as follows:

a) Nomination

(i) When a vacancy arises, the ICB will create a role description, which will set out the expectations associated with the role (including the expected skills, knowledge, time commitment and term of office) and shall issue that role description to the eligible VCSE organisations referred to at 3.8.1, together with an invitation to nominate, a timeline for the nomination and setting out any further information about the nomination and appointment process.

(ii) The nomination process will be managed by the eligible VCSE organisations named at 3.8.1 above, with advice and support from the ICB's governance team as appropriate.

(iii) Those eligible VCSE organisations participating in the nomination of candidates shall: (a) ensure candidates who are nominated are eligible for the role in accordance with the criteria for eligibility and disqualification set out above; and (b) have due regard to the role description.

(iv) The aim of the nominations process shall be for the eligible VCSE organisations to determine a jointly agreed individual or individuals to be put forward for appointment. Accordingly, the eligible VCSE organisations shall put forward to the Chief Executive a single agreed list of those they are putting forward to be considered for appointment under step b) below.

b) Appointment

(i) Appointment will be made as a result of a formal assessment by the Chief Executive (with the support of an ICB governance officer, as appropriate) against the expectations of the role description and the eligibility and disqualification criteria for Board membership as set out above and to ensure the individual has the ability to contribute effectively to the overall functioning of the Board. Should this result in more than one individual being eligible and suitable for appointment to the role, then a subsequent interview process will take place.

(ii) Should no individual be nominated, or no individual be eligible or determined as suitable for appointment following assessment, then the nominations process described above shall be repeated.

(iii) Appointment to the role will always be subject to approval by the Chair.

3.8.6 The normal term of office for this role will be three years in duration and in accordance with the letter of appointment to the role, following which the VCSE organisations will be asked to nominate an individual in accordance with the process set out at 3.8.5 above. An individual will only be eligible for further nomination and reappointment if they continue to meet the relevant criteria outlined above.

3.8.7 Initial appointments may be for a shorter term (i.e. less than three years), in order to avoid all Ordinary Members retiring at once.

3.9 Role fulfilling that of ICB Medical Director

3.9.1 This member will fulfil the eligibility criteria set out at 3.1.1 and also the following additional eligibility criteria:

a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the state or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;

b) be a medical practitioner with current valid registration with the General Medical Council.

3.9.2 Individuals will not be eligible if 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 Nursing Officer

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

a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the state or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;

b) be a nurse with current valid registration with the Nursing and Midwifery Council.

3.10.2 Individuals will not be eligible if 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 and Performance Officer

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

a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the state or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;

b) have a professional qualification in accountancy and the expertise or experience to lead the financial management of the ICB.

3.11.2 Individuals will not be eligible if 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 Three Non-Executive Members

3.12.1 The ICB will appoint three non-executive members.

3.12.2 These members will be appointed by the Chief Executive subject to the approval of the Chair.

3.12.3 The Chair may appoint one such non-executive member as the senior non-executive member and Deputy Chair. The non-executive member appointed by the Chair as the senior non-executive member and Deputy Chair shall not be the Chair of the ICB's Audit and Risk Committee.

3.12.4 These members will fulfil the eligibility criteria set out at 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 which provides services in the Area;

c) one shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit and Risk Committee;

d) another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee.

3.12.5 Individuals will not be eligible if any of the disqualification criteria set out in 3.2 apply.

3.12.6 The normal term of office for a non-executive member will be three years in duration. Initial appointments may be for a shorter term (i.e. less than three years), in order to avoid all non-executive members retiring at once.

3.12.7 Subject to satisfactory appraisal the Chair may approve the reappointment of a non-executive member up to the maximum number of terms permitted for their role. An individual will only be eligible for further reappointment if they continue to meet the relevant criteria outlined above.

3.12.8 An individual may serve a maximum of three terms. However, at the discretion of the Chair, an individual's appointed third term of office (if any) may be extended by a further single year.

3.13 Board Members: Removal from Office

3.13.1 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.

3.13.2 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) they fail to attend three consecutive Board meetings (except under extenuating circumstances, such as illness, and with the agreement of the Chair);

c) they are deemed to not meet the expected standards of performance at their annual appraisal;

d) they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the reputation, honour and/or 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) they are deemed to have failed to uphold the Nolan Principles;

f) they are subject to disciplinary action by a regulator or professional body.

3.13.3 Board Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.13.2 apply.

3.13.4 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.

3.13.5 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.

3.13.6 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.

3.14 Terms of Appointment of Board Members

3.14.1 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 on the ICB's website and

any guidance issued by NHS England or other relevant body. Remuneration for the Chair will be set by NHS England. As detailed in the Handbook, remuneration for non-executive members will be set by a committee constituted of the Chair, the Chief Executive and three Partner Members ('the Non-Executive Member Remuneration Committee').

3.14.2 Other terms of appointment will be determined by the Remuneration Committee.

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

3.15 Specific arrangements for appointment of Ordinary Members made at establishment

3.15.1 Individuals may be identified as "Designate Ordinary Members" prior to the ICB being established on 1 July 2022.

3.15.2 Relevant nomination procedures for Partner Members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the provisions of 3.5 to 3.7 of this Constitution.

3.15.3 Any appointment and assessment processes undertaken in advance of establishment of the ICB to identify Designate Ordinary Members should follow, as far as possible, the processes set out in sections 3.5 to 3.12 of this Constitution. However, a modified process, agreed by the Chair, will be considered valid.

3.15.4 On the day of establishment, a committee consisting of the Chair and Chief Executive will appoint the Ordinary Members who are expected to be all individuals who have been identified as designate appointees pre ICB establishment and the Chair will approve those appointments.

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

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 and any governance guidance issued by NHS England.

4.1.2 The ICB has agreed a code of conduct and behaviours 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 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 Area.

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with a)–f) above, documenting them as necessary in this Constitution, the 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 Board 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 secondary legislation for the ICB's functions to be exercised by or jointly with any one or more of those other bodies. In addition, the ICB may arrange for functions of that other body or bodies to be exercised by or jointly with the ICB.

4.3.3 Where the ICB and any one or more other body arranges to exercise certain functions jointly, whether under section 65Z5 or otherwise, 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.

4.3.4 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. The ICB and local authority may also establish a pooled fund in relation to the functions in question.

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

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full in the Handbook.

4.4.2 Only the Board may agree the SoRD, and amendments to the SoRD may only be approved by the Board, on the recommendation of the Chair or Chief Executive.

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, 65Z6 or 75 of the 2006 Act.

4.4.4 The ICB remains accountable for all 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.northeastlondonicb.nhs.uk

4.5.3 The map includes:

a) key functions reserved to the Board;

b) commissioning functions delegated to committees and individuals;

c) commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body;

d) functions delegated to the ICB (for example, from NHS England).

4.6 Committees and Sub-Committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. If permitted by its terms of reference, a 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 Board. All terms of reference are published in the Handbook.

4.6.4 The Board remains accountable for all functions, including those that it has delegated to committees and sub-committees 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 comply with reporting and assurance arrangements set out in their terms of reference.

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 ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual's membership of 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, the code of conduct set out in the Handbook, and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

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

b) **Remuneration Committee**: 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 Audit and Risk Committee.

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

4.7 Delegations made under section 65Z5 of the 2006 Act

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

4.7.2 All delegations made under these arrangements are set out in the SoRD and are included in the Functions and Decision Map.

4.7.3 Delegation arrangements made under section 65Z5 of the 2006 Act may be made on such terms as agreed between the parties, and will be set out in a delegation arrangement setting out those terms. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the Board.

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

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;
- 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 in the Handbook.

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 which are available through its website at www.northeastlondonicb.nhs.uk

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 ICB's Conflicts of Interest policy and procedures and the Standards of Business Conduct policy.

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

a) act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;

b) be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;

c) support the rigorous application of conflict of interest principles and policies;

d) provide independent advice and judgement to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;

e) provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions, the ICB will abide by the following principles as they relate to its arrangements for managing conflicts of interest:

a) The Nolan Principles;

b) Ensuring clear policy guidance is provided to all those performing a role on behalf of the ICB;

c) Monitoring compliance in accordance with published guidance;

d) Ensuring interests are proactively declared at the point individuals become involved in decision making;

e) Adopting a proportionate, common sense approach to the management of conflicts of interest;

f) Keeping an audit trail of actions taken; and

g) Such other principles as contained in the ICB's Conflicts of Interest policy and procedures.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

a) Board Members;

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's website. The registers can be found at at www.northeastlondonicb.nhs.uk

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 before 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.

6.4 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 Nolan Principles;

c) comply with the ICB Standards of Business Conduct Policy and any requirements set out in that policy for managing conflicts of interest;

d) comply with the ICB's Conflict of Interest policy and procedures.

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 and the ICB's Conflict of Interest policy and procedures.

Arrangements for ensuring Accountability and Transparency

7.1.1 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 meetings, and committees composed entirely of Board Members or which include all Board Members, will be held in public, except where the Board or committee resolves into private session, in accordance with Standing Order 4.10.

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's 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 Handbook will be published as well as other key documents, including but not limited to:

a) Conflicts of Interest policy and procedures;

b) registers of interests.

7.2.8 The ICB will publish, with its 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 to 223N (financial duties);

c) set out any steps that the ICB proposes to take to implement the eight joint local health and wellbeing strategies prepared by the Health and Wellbeing Boards on behalf of the ICB and each of the eight partner local authorities listed at 1.3.1;

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; and

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 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.

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

7.3.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including complying with existing procurement rules until the provider selection regime comes into effect.

7.3.4 The ICB will comply with its duties in relation to health overview and scrutiny by local authorities.

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 sections:

- 14Z34 (improvement in quality of services);
- 14Z35 (reducing inequalities);
- 14Z36 (promotion of involvement of patients);
- 14Z37 (patient choice);
- 14Z38 (obtaining appropriate advice);
- 14Z39 (promoting innovation);
- 14Z40 (research);
- 14Z41 (promotion of education and training);
- 14Z42 (promotion of integration);
- 14Z43 (have regard to the effect of decisions);
- 14Z44 (as to climate change);
- 14Z45 (public involvement and consultation); and

- 14Z49 (keeping experience of Board Members under review).

b) Review the extent to which the ICB has exercised its functions in accordance with the plans published under sections:

- 14Z52 (Joint Forward Plan); and
- 14Z56 (joint 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).

d) Review any steps the Board 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.

Arrangements for Determining the Terms and Conditions of Employees

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

8.1.2 The Board has established a Remuneration Committee, which is chaired by a non-executive member other than the Chair or Audit and Risk Chair.

8.1.3 The Board has approved terms of reference for the Remuneration Committee, which are contained in the Handbook.

8.1.4 The membership of the Remuneration Committee is determined by the Board and is set out in the terms of reference for the committee. No employees may be a member of the Remuneration Committee, but the Board ensures that the Remuneration Committee has access to appropriate advice by:

a) ensuring the most senior HR director and/or their nominated team members are in attendance;

b) authorising the Remuneration Committee to obtain legal and/or other independent advice and to secure the attendance of anyone with relevant experience and expertise, if the committee considers this necessary.

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

8.1.6 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.

8.1.7 The duties of the Remuneration Committee shall include:

a) determining the ICB's pay policy and standard terms and conditions;

b) agreeing arrangements for the remuneration of Board Members (other than the Chair and the three non-executive members) in line with relevant policy;

c) making arrangements for the remuneration of employees and members of the ICB's committees and sub-committees;

d) such other duties as set out in the terms of reference for the Remuneration Committee contained in the Handbook.

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

Arrangements for Public Involvement

9.1.1 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:

a) the planning of the commissioning arrangements by the ICB;

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 as described in b).

9.1.2 In line with section 14Z54 of the 2006 Act, when preparing the Joint Forward Plan or revising the plan in a way they consider significant, the ICB together with its partner NHS trusts and NHS foundation trusts will take appropriate steps to ensure that they:

a) involve the Health and Wellbeing Boards;

b) consult its population.

9.1.3 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; and

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

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

9.1.5 These arrangements may include:

a) using public engagement and insight to inform decision making;

b) adopting engagement activities and methods to meet specific needs of different patient groups and communities;

c) redesigning models of care and tackling system priorities in partnership with staff, people who use care and support and unpaid carers;

d) working with Healthwatch and the VCSE sector as key transformation partners;

e) understanding the community's experience and aspirations for health and care;

f) reaching out to excluded groups, especially those affected by inequalities;

g) providing clear and accessible public information about vision, plans and progress to build understanding and trust;

h) using community development approaches that empower people and communities.

Appendix 1: Definitions of Terms Used in this Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
Area	The geographical area that the ICB has responsibility for, as defined in clause 1.3 of this Constitution.
Board	The Board of the ICB.
Committee	A committee created and appointed by the Board.
Executive Director	The following Board Members: • Chief Executive • Chief Finance and Performance Officer • Chief Nursing Officer • The role fulfilling that of ICB Medical Director
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.
Handbook	The ICB's Governance Handbook maintained and published by the ICB. The Handbook includes key corporate governance documents, including terms of reference for the ICB's Committees and Sub-Committees.
Health and Wellbeing Boards	The committees of the eight local authorities listed in paragraph 1.3.1 which are established under section 194 of the Health and Social Care Act 2012 and are in the Area, namely: • The Barking and Dagenham Health and Wellbeing Board • The Havering Health and Wellbeing Board • The Health and Wellbeing Board for the City of London • The Hackney Health and Wellbeing Board • Newham Health and Wellbeing Board • The Redbridge Health and Wellbeing Board • Tower Hamlets Health and Wellbeing Board • Waltham Forest Health and Wellbeing Board
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.
Health Service Body	Health Service Body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.

ICB Board	Members of the ICB.
Integrated Care Partnership	The joint committee for the Area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area. Those local authorities are listed above at 1.3.1. The Integrated Care Partnership's functions include a duty to prepare an "integrated care strategy" in accordance with section 116ZA of the Local Government and Public Involvement in Health Act 2007 as amended by the Health and Care Act 2022.
Joint Forward Plan	The system plan prepared before the start of each financial year by the ICB and its partner NHS trusts and NHS foundation trusts, in accordance with section 14Z52 of the 2006 Act.
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.
Nolan Principles	The Seven Principles of Public Life, which are: selflessness, integrity, objectivity, accountability, openness, honesty, and leadership.
Ordinary Member	The Board will have a Chair and a Chief Executive plus other members. All such other members of the Board are referred to as Ordinary Members.
Partner Members	Partner Members are the six Ordinary Members from the local authorities, the NHS organisations and the GP practices, as referred to at paragraph 2.1.5 of the Constitution. Partner Members bring knowledge and a perspective from their sectors and are appointed in accordance with the nominations, appointment and approval processes described in section 0 of the Constitution.
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 ICB, local government and providers of health and care services, including the VCSE sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
The Primary Medical Services Selection	A panel which is convened and chaired by the Chief Executive in order to consider appointments to the Primary Medical Services – Partner Member roles. The Panel will be supported by a governance officer from the ICB and shall be constituted of the following:

Panel ('the Panel')	a) the Chief Executive; b) the Chair; c) two Local Medical Committee representatives, from Barking and Dagenham and Havering LMC and Londonwide LMC local leadership; d) an independent representative from a London region ICS (not NEL).
Sub-Committee	A committee created and appointed by and reporting to a committee.
VCSE	Voluntary Community and Social Enterprise.

Appendix 2: Standing Orders

1. Introduction

1.1 These Standing Orders have been drawn up to regulate the proceedings of the ICB so that it can fulfil its obligations as set out largely in the 2006 Act. They form part of the ICB's Constitution, and definitions used in that document apply accordingly.

2. Amendment and review

2.1 The Standing Orders are effective from 1 July 2022.

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

2.3 Amendments to these Standing Orders will be made as per clause 1.6.2 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 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 or the Constitution, the Chair, supported with advice from the director responsible for governance, 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. Where any non-compliance relates to the Chief Executive, it should be disclosed to the Chair.

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 and Risk Committee for review.

4. Meetings of the ICB

4.1 Calling Board Meetings

4.1.1 Meetings of the Board 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 10 calendar days' notice in writing.

b) at least one third of Board Members, acting together, 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.

d) a failure to give one month's notice, as intended in normal circumstances in accordance with the above requirement, shall not invalidate a decision otherwise taken in accordance with the Standing Orders.

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 and electronically by publication on the ICB's website at least three clear days before the meeting. Where a meeting is called on an urgent basis in accordance with 4.1.2c) a public notice shall be posted at the time the meeting is called.

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 that 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 appointed in accordance with 3.12.3 shall preside over the meeting. Where the Deputy Chair is also absent or conflicted, the Board Members present shall agree who will preside over the meeting in the Chair's absence.

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

4.3 Agenda, supporting papers and business to be transacted

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

4.3.2 Except where the emergency provisions apply:

a) terms of business to be transacted for inclusion on the agenda of a meeting and the text of any proposed resolutions need to be notified to the Chair (copied to the secretariat) at least seven days before the meeting takes place;

b) supporting papers for all items must be submitted to the secretariat at least five calendar days before the meeting takes place;

c) the agenda and supporting papers will be circulated to all members of the Board at least three 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.northeastlondonicb.nhs.uk

4.4 Nominated Deputies

4.4.1 With the permission of the person presiding over the meeting, the Executive Directors, the Partner Members and the VCSE member 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.

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

4.5 Virtual attendance at meetings

4.5.1 The Board and its committees and sub-committees may meet virtually using telephone, video and other electronic means, in accordance with any specific requirements for virtual attendance at meetings set out in the relevant committee or subcommittee's terms of reference.

4.5.2 Notwithstanding Standing Order 4.5.1 the chair of any meeting of the Board, committee or subcommittee may permit virtual attendance at a meeting where the chair considers that doing so would facilitate the participation of a member or participant who would otherwise be unable to attend.

4.6 Quorum

4.6.1 The quorum for meetings of the Board will be five members, including:

a) either the Chief Executive or Chief Finance and Performance Officer; and

b) either the individual fulfilling the role of ICB Medical Director or Chief Nursing Officer; and

c) at least one non-executive Member; and

d) at least one Partner Member.

4.6.2 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 4.4 will count towards quorum for meetings of the Board.

4.6.3 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.

4.7 Vacancies and defects in appointments

4.7.1 The validity of any act of the Board is not affected by any vacancy amongst its Board Members or by any defect in the appointment of a Board Member.

4.7.2 In the event of a vacancy, or a defect in appointment which is known in advance of a meeting, the quoracy requirements set out in Standing

Order 4.6 shall continue to apply. Where a defect in appointment is discovered once a meeting has commenced or after a meeting has concluded, that defective appointment will not invalidate the quoracy of the meeting or a decision that has been taken.

4.8 Decision making

4.8.1 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.

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

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

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

c) For the sake of clarity, any additional participants (as detailed within paragraph 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.

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

Disputes

4.8.3 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

4.8.4 In the case of urgent decisions and/or 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 Chair of the ICB and Chief Executive subject to every effort having been made to consult with as many members as possible in the given circumstances.

b) The exercise of such powers shall be reported to the next formal meeting of the Board for formal ratification and to the Audit and Risk Committee for oversight.

c) Before resolving to use the powers set out in Standing Order 4.8.4a), the Chair must consider whether a virtual meeting of the Board could be convened.

4.8.5 In the case of committees, sub-committees and joint committees established by the Board, any urgent decision-making powers will be as set out in the terms of reference for that committee, sub-committee or joint committee.

4.9 Minutes

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

4.9.2 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.

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

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

4.10 Admission of public and the press

4.10.1 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 which include all Board Members, at which public functions are exercised, will be open to the public.

4.10.2 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.

4.10.3 The person presiding over the meeting shall give such directions as they think 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.

4.10.4 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.

4.10.5 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 and Risk Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Use of seal and authorisation of documents

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

a) the Chief Executive;

b) the Chair;

c) the Chief Finance and Performance Officer;

d) any two duly authorised executive directors.