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WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Date: Tuesday, 29th March, 2022
Time: 10.00 am hours
Venue: Via Zoom Meeting
Please click on this link to view the meeting: YouTube – Calderdale Council

Everyone is welcome to attend this Scrutiny Board.

Access to the Meeting

This meeting will be streamed live on Calderdale Council's YouTube site. This allows members of the public to view the meeting proceedings as they take place. If you have a question you wish to ask on a particular item, please inform the Chair and Scrutiny Team ahead of the meeting, (details can be found at the end of this agenda).

Reports

Whilst we are working remotely during the COVID-19 pandemic, electronic copies of papers can be accessed on the Council's website, please visit: http://www.calderdale.gov.uk/council/councillors/councilmeetings/index.jsp

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Membership of the Board

Councillor	Vanda Greenwood (Chair) – Bradford Metropolitan District Council
Councillor	Liz Smaje (Deputy Chair) – Kirklees Council
Councillors	Julie Glentworth – Bradford Metropolitan District Council
	Stephen Baines MBE - Calderdale Metropolitan Borough Council
	Colin Hutchinson - Calderdale Metropolitan Borough Council
	Jackie Ramsay – Kirklees Council
	Abigail Marshall Katung - Leeds City Council
	Graham Latty - Leeds City Council
	Jim Clark - North Yorkshire County Council
	Andy Solloway - North Yorkshire County Council
	Betty Rhodes - Wakefield Metropolitan District Council
	Kevin Swift - Wakefield Metropolitan District Council

A G E N D A

1. **Substitutes nominated for this meeting and apologies for absence**

2. **Members' Interests**
   To remind Members of the need to declare any disclosable pecuniary interests or other interests they might have in relation to the items included on this agenda.

3. **Admission of the Public**
   It is not recommended that the public be excluded from the meeting for the consideration of the items of business on this agenda.

4. **Public Deputations**
   At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations on matters relevant to the agenda of this meeting of the Joint Committee.

   As this is a "virtual" meeting, anybody wishing to make a deputation should submit their deputation by email to Scrutiny@calderdale.gov.uk
   By midday on 28th March 2022 and should take no longer than 2 minutes per question.

   Due to the number and/or nature of comments it may not be possible to provide responses immediately at the meeting. If this is the case, the Joint Committee will indicate how the issue(s) raised will be progressed.

5. **Minutes of the Meeting held on 30th November 2021 to be agreed as a correct record and signed by the Chair. (Pages 5 - 14)**

6. **Integrated Care System Governance (Stephen Gregg, Governance Lead - West Yorkshire Health and Care Partnership) (Pages 15 - 114)**
   This item will include discussion of:

   - The handbook to accompany the West Yorkshire Care Partnership constitution
   - The revised Constitution
   - Update on the appointment of Chairs for place-based committees and non-executive directors
   - Other current issues

7. **West Yorkshire Mental Health, Learning Disability and Autism Collaborative (Keir Shillaker - West Yorkshire Health and Care Partnership) (Pages 115 - 130)**

   Attached is a report that describes

   - The overall operating model for Mental Health, Learning Disability and Autism (MHLDA) in West Yorkshire
   - The role of the MHLDA collaborative and its governance as part of the West Yorkshire operating model
   - Examples of some areas of work being taken forward at West Yorkshire level, and the interface between the place, system and the Collaborative:

- Children & Young People's Mental Health
- Suicide Prevention
- Neurodiversity
- Psychiatric Intensive Care (PICU)
- Community Mental Health Transformation

8. **Work Plan and Next Steps**

Information about the Board

Scrutiny Boards represent the interests of local people about important issues that affect them. They look at how the decisions, policies and services of the Council and other key public agencies impact on the city and its residents. Scrutiny Boards do not take decisions but can make recommendations to decision-makers about how they are delivering the Community Strategy, an agreed vision for a better Calderdale that is shared by public agencies across the borough.

The Council wants to consult people as fully as possible before making decisions that affect them. Members of the public do not have a right to speak at meetings, but may do so if invited by the Chair. If you have a special interest in an item on the agenda and want to speak, tell the Assistant Scrutiny Officer, who will pass on your request to the Chair. Groups of people will usually be asked to nominate a spokesperson. The Council wants its meetings to be as open as possible, but occasionally there will be some confidential business. Brief reasons for confidentiality will be shown on the agenda sheet.

Agenda, reports and minutes of all Council Committees and Boards can be found on the Council's website.

I R Hughes
Head of Legal and Democratic Services
Town Hall, HX1 1UJ
Monday, 21 March 2022

For further information on this agenda please contact MIke Lodge/Farzana Hussain on Mike.Lodge@calderdale.gov.uk or Farzana.Hussain@calderdale.gov.uk or 01422 393250

The agenda papers for this meeting are available on the Council's Website.

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WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE,
Tuesday, 30th November, 2021

PRESENT: Councillor Greenwood (Chair)
Councillors: Smaje, Clark, Glentworth, Katung, Latty, Ramsay, Rhodes and Swift

10 SUBSTITUTES NOMINATED FOR THIS MEETING AND APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Solloway (North Yorkshire)

(The meeting closed at 13:05 hours).

11 PUBLIC DEPUTATIONS

There were three public deputations received from Jenny Shepherd, Rosemary Hedges and Christine Hyde. A summary of the deputation appears below. The full deputation will be published with the minutes.

Jenny Shepherd

The consultation on the draft IC Board constitution cannot meaningfully proceed without the IC Board Governance Handbook, which is omitted from the draft constitution and its annexes. The draft constitution says that the ICS Governance Handbook will include the terms of reference for all IC Board committees, subcommittees and joint committees that exercise its functions, including the delegation arrangements. This is about which bodies are to have decision-making roles in NHS commissioning, and what the membership of those bodies will be. Given the obscurity of NHS procurement/contracting processes under the new Provider Selection Regime that is to replace current contracting regulations and legislation, it is vital that the Constitution is clear about the delegation of the IC Board's commissioning functions. Without clarity on these matters, the constitution is a hollow shell which potentially allows almost anything to take place with regard to NHS commissioning decisions. This is a totally unacceptable state of affairs, as we have seen from the corrupt contracting that's resulted from the DHSC's black box commissioning of Covid19- related goods and services.

Rosemary Hedges

The draft IC Board Constitution's arrangements for public participation are weak.

I propose that the IC Board constitution should strengthen them as follows. (refer to full deputation in the papers)

- Arrangements for public participation in meetings of the IC Board (and any other bodies that it delegates its functions to) should be no less than current arrangements for public participation in the non-statutory ICS Board meetings and CCG meetings.
- The constitution should say IC Board agendas, papers and minutes will be published electronically and at the offices of the ICB body at least 7 clear days before the meeting
- The draft IC Board constitution arrangements for consulting IC Board population on its system plan (9.2) are inadequate as a means of involving the public in the

exercise of IC Board functions. They should be replaced with arrangements that offer a real way of involving the public.

- The Constitution should specify that ICB compliance with local authority health overview and scrutiny requirements includes joint WY local authorities' health overview and scrutiny requirements

Christine Hyde

We think the IC Board membership should be broader, to include the public, Trade Unions and the vital but overlooked clinical services, NHS Dentistry and NHS maternity services.

Several aspects of the draft constitution section on Integrated Care Board membership arrangements need clarification. (refer to full deputation in the papers)

- Composition of IC Board
- Clarification of IC Board membership arrangements

12 MINUTES OF THE MEETING HELD ON 20TH JULY 2021 TO BE AGREED AS A CORRECT RECORD AND SIGNED BY THE CHAIR.

IT WAS AGREED that the minutes from the meeting held on 20th July 2021, be approved as an accurate record.

13 WEST YORKSHIRE INTEGRATED CARE BOARD - DRAFT CONSTITUTION

Officers presented the Partnership's developing governance arrangements to the West Yorkshire Joint Health Overview and Scrutiny Committee (JHOSC) in July 2021. The report now presents the draft constitution of the West Yorkshire Integrated Care Board (ICB). From April 2022, subject to legislation, ICBs will take on the commissioning responsibilities of Clinical Commissioning Groups and lead the integration of health and care services across their area.

The draft constitution has been added to the website to enable all interested parties to contribute. The report seeks comments on the constitution and poses some specific questions on which feedback would be welcomed. It is important to note that feedback is sought on the content of the constitution, not on whether ICBs should be established – as the latter will be required by law.

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

Members commented on the following issues:

- Councillor Hutchinson advised that there will be huge amounts of public money invested within the integrated care system and that it is essential for there to be something in place where the public would feel confident in seeing the money was being spent accordingly. He also mentioned that it was impossible to consult

over the constitution without having seen the Government handbook and suggested for members to re-review once more information had been made available. Councillor Hutchinson advised that he was surprised to read that the vision of West Yorkshire Health Care Partnership was set out in Clause 11-15, that there was no mention of that vision being the provision of a comprehensive health system to the people of West Yorkshire. He wanted to know why this had not been a key part of the vision. In response, Officers advised that they realise more work is required and can confirm that they will be working and engaging with partners more to get that information out. He further advised that in terms of the comprehensive health system, the vision had been taken from a previous ICS document which may be amended whilst the document is worked on.

- Councillor Hutchinson asked for confirmation with regards to section 1.3 in the constitution. He advised that it defined the area covered by the integrated care board but there was no definition of the people of whom the Board had a duty to procure the provision of health and care Services. He provided the board with an example from the Manchester Evening News of a woman suffering from burns had been turned away from two NHS units because of a protocol put in place by Northern Care Alliance. He wanted to know if anything had been put in this constitution to prevent such a thing happening here. He suggested this should be clearly stated in the constitution. (under the new arrangements). In response, Officers confirmed that people would not be turned away for emergency treatment, the same arrangements would apply as the current ones.

- Councillor Smaje asked for confirmation with regards to the positions on the board outlined in the constitution, how can you ensure the number of places in the board and would the voices be from different places on the Board? Which people will be eligible to apply for the positions and from which organisations? In response, Officers advised that it is key that they get the perspective of each of the places. He advised they have a representative from each place, and this has been built in. Officers further advised that they are trying to maintain the ethos they have which is based on the principle of subsidiarity - do as much as possible, as close to the place as possible and as close to the neighbourhood as possible. Councillor Smaje further requested the officers to advise on the hospital reconfiguration and asked if there was ability for two places to come together like the CCG's come together and form a committee and make decisions. Would this then go to the ICB? And once gone to the ICB do they make a decision? In response, officer advised they would not be able to cover every combination of decision at individual place level in the constitution. The principle of board members and place committee members are there to bring their broader perspective of the sector.

- Councillor Swift commented on the issue of public engagement and the difficulties that follow on from this within the constitution. He advised that the powers were at different levels which were not clearly defined.

- Councillor Rhodes requested to know about the time frame around the implementation of the ICS and also wanted to know when it would be ready for this committee to have sight of it so they could comment further on any missing detail. Councillor also wanted to know where else had it been published/advertised that there is a constitution going on? In response, Officers suggested to hold a meeting in January for members to have the chance to

consider the handbook and go through questions and answers in greater depth. The Government plan is for the constitution to be implemented by 1st April 2022. If, however it is not ready, there will be a contingency.

- Councillor Hutchinson advised that the constitution had three areas which were not covered appropriately in the constitution. The first being the NHS workforce. Councillor Hutchinson wanted to know why there was no committee or subcommittee for workforce? He also wondered whether the voice of social care will be sufficiently heard on the board? The public feel that the process of integration is supposed to be integration of health and social care, however, there seems to be imbalance in the makeup of the board. Councillor Hutchinson also asked why the constitution did not define the relationship between health and wellbeing boards and the integrated care board. In response, Officers advised that the NHS is made up of the people and workforce, and it's where the money is spent and invested in, who deliver the care and support. The current approach is that the People Board is a programme and not a committee of the board. There is a strong group which is led by health education England from trusts who come together and plan on the recruitment and retention, apprenticeships etc. Officers advised that the point regarding social care would require strengthening with our partners and local councils, heads of department etc. In relation to the third point, officer advised that they would be willing to put some additional material in the constitution regarding the health and wellbeing boards and suggested that the councils and scrutiny officers may be interested in. Councillor Hutchinson suggested the officers consider establishing a People Committee.

- Councillor Smaje asked the Officers if they had a communications plan for how they were running the engagement of the constitution and wondered if they could see it before January to comment on. She also mentioned that when looking at services, it's a whole system and advised that without the whole system, the different parts don't operate as effectively - the whole system should be viewed when taking decisions. In response, officer advised that they were happy to share the engagement/consultation plan with members.

- Councillor Marshall-Katung requested for the Officers to shed light on the term 'place' so that the general public could understand. In response, officer advised that the intention behind the term 'place' was that it's where people live and where they feel a connection with.

14 YORKSHIRE AMBULANCE SERVICE

Since the start of the COVID-19 pandemic, Yorkshire Ambulance Service (YAS), has seen an unprecedented impact on its services and the communities it serves.

All areas of its service have been impacted, covering.

- Accident and Emergency Operations, (both receiving 999 calls and responding to them).

- Integrated Urgent Care (IUC) service (including the NHS 111 urgent medical help and advice line); and

- non-emergency Patient Transport Service, PTS, (taking eligible patients to and from their hospital appointments and treatments).

The ongoing pressures and exceptional levels of demand for services, coupled with higher staff sickness levels and the wider pressures across the whole of the NHS system, have been felt across the whole Yorkshire and Humber region and are comparable with pressures usually only seen in the ambulance service in the most severe winters. YAS is in its highest level of escalation and has been since 9 July 2021, reflecting the extreme pressure services are under and all 10 English ambulance services are in the same position. The recent publication of the monthly NHS England statistics showed that ambulance services had their busiest month ever in October, answering 1,012,143 calls.

Members commented on the following issues:

- Councillor Hutchinson mentioned that the peak demand period for the NHS is in January and February and wondered how YAS will deal with the anticipated demand. Has there been progress in reducing handover times at the hospitals throughout the region? Also, reports have shown that more people are accessing accident and emergency as they cannot get services from primary care. Had these concerns been reflected in the figures of the numbers of people who call the crew out but then don't need to attend hospital? In response, officer advised that other parts of the health and social care are also experiencing high demand in general. There has been no reduction in handovers so far, however we have had constructive meetings with partners across the sector, where everyone recognises that we need to do everything to minimise the risk of harmed patients and to reduce ambulance delays. Some of the immediate things that have been discussed are, ambulance divert policies, potentially cohorting patients at the emergency department, where paramedics would be looking after more than one patient and rapid triage by clinical staff.

- The Chair commented on mental wellbeing and that they had heard of people contacting the ambulance services because they felt safe there. She wondered if this was something that the YAS were tackling or was it something that councils needed to look further into with mental health support partners. In response, Officers advised that they have a frequent caller's team who work on a case management approach. If people are calling a number of times, they work in partnership with mental health services and other agencies to get the best response for these patients – this has been really effective.

- Councillor Smaje asked about the management of demand and waiting times. She wondered what work was being done to look at what extra things needed to be put in place to reduce certain pressures for people to be given support but not necessarily go to hospital. In response, Officers advised that there are a number of different services who respond to the calls. They have emergency crews and volunteers who could also be sent to respond. He confirmed that they do signpost people to other health services, including voluntary services. Ten percent of the calls that come through the 999 services are responded to just by phone and signposted accordingly, or clinical advice given via phone. The Officer advised that they were continuingly looking at different pathways to care, which included being able to book patients into direct emergency clinics and GP clinics

which are part of the community sector. He further advised that a lot of work was being done to increase alternative pathways to care.

- Councillor Smaje asked what involvement would YAS have in the new arrangements for the ICS and different places as the ambulance service is part of that system. How will the ICB partnerships connect with YAS to be able to give you information on places? In response, Officers advised that YAS are stitched into the ICB arrangements. They also have an integrated commissioning forum which brings together representatives from the three ICSs across Yorkshire and is informed by discussions at place. Officers advised that they are looking to strengthen their specialist and advance paramedic arrangements so that they are better connected into place-based arrangements. They are also planning to increase the number of paramedics.

- Councillor Ramsay asked about the lost hours due to hand over delays. She wanted to know what work was being done around this. In response, Officers advised that they were confident that the conversations they had been having with clinical leads across health and social care will lead to improvements as the winter period approaches.

- Councillor Rhodes asked about waiting times. She mentioned that the waiting times were far too long. Is there any way that the transport arrangements for the clinics could be reviewed? In response, Officers advised that in terms of the number of non-emergency patient transport vehicle journeys that are being done, it is 30% higher than prior to the pandemic, which has required a huge effort from the service. The national review was published regarding the non-emergency patient transport which looked at how services could be improved and provide better responses who attend hospital clinics and work better in partnerships. The booking arrangements are required to be made easier for people and this is being looked at. Additional staff have been recruited within the contact centre to improve call response time.

IT WAS AGREED that the report be noted.

15 WEST YORKSHIRE PEOPLE PLAN

The health and care five-year plan made a commitment to develop a system wide workforce plan by early 2020 that is inclusive of all staff from health and social care; to set out how future demand can be achieved via various means such as increasing supply, retention strategies and upskilling the current workforce, supporting new models of care, international recruitment and new role development.

The ongoing response to COVID-19 has impacted on delivering a ‘People Plan’ in this timeframe but has also given us the opportunity to take the learning from how we have adapted and responded to the pandemic to inform the ‘People Plan’ priorities. We are clear that this spans the whole of the workforce including social care.

The workforce continues to face increasing pressures and there are challenges that we need to address in the here and now, but we also need to plan for the future – the ‘People Plan’ aims to set out how we intend to address the immediate challenges but also the strategic ambitions for the future.

Building on the NHS People Plan, the West Yorkshire (WY) People Plan is for our 'One Workforce' across health, social care, the Voluntary Community and Social Enterprise (VCSE) and also recognised the contribution from our unpaid carers, and is framed around five pillars:

- System leadership to develop the partnership
- Looking after our people
- Belonging in the health and care partnership
- New ways of working and delivering care
- Grow for the future

Whilst the plan itself set out the commitments and intent, it will be the actions that we deliver as a system that will make the difference to our people.

Members commented on the following issues:

- Councillor Hutchinson mentioned that in April 2018, Health Education England published a healthy place to live, a great place to work a workforce strategy – which had flagged up the problems that faced developing a strategy. He mentioned that he was unable to see the progress in this people plan. Councillor Hutchinson said there had been lots of gaps in the workforce and it should be where the focus is. Reports from Leeds Teaching Hospital and NHS Trust suggest there are 700 vacancies for nurses and midwives, and nearly 287 operations had to be postponed due to lack of staff in critical care. General Practice is also suffering. The report does not show these gaps. Councillor Hutchinson advised that the report gave no indication on shortages of staff in various services and there was no urgency in dealing with this issue. In response, Officers advised that the people plan was a strategy and not a detailed workforce plan and would not be highlighting the workforce statistics. Officers confirmed that work was underway on looking at recruitment and how those challenges could be met. Councillor Hutchinson asked when could members see the plan and not the strategy? In response, officer advised that they would have a duty from the 1st of April to develop a five-year workforce plan for the health and care system. Rob Webster advised that they had a set of arrangements for half of the year where they have looked at staff recruitment etc. He also confirmed that workforce plans are an urgency as it is the people who deliver. International recruitment work is also being done.

- The Chair asked if the Officers knew what the shortage statistics were in West Yorkshire in terms of staff? In response, Officers advised that currently, there is a 10% vacancy rate for registered mental health nurses and therefore blended teams are required to be formed. He mentioned that it would vary depending on the discipline and further advised that it would be easier to recruit health care support workers than registered nurses. Currently, there would be 100,000 vacancies across the country.

- Councillor Smaje wanted to know how the issues with staffing had been dealt with across the trusts. She mentioned that there were issues pre-pandemic, and problems in some areas where services were having to change. The report did not address any of these issues. Most importantly, there is no mention on staff working across the trusts to be able to deliver services effectively and safely in the places where people need the services. In response, Officers advised there

is not only one solution to these issues. Officers advised that a combination of what was in the paper will be part of the solution, which included training staff and working with colleagues in developing them; working with trusts to support and tackle challenges; and looking at new roles and maximising what the new roles could bring. Officers further advised that the approach they are taking is to be flexible and as approachable as possible, in terms of training. The apprenticeship route is advantageous. In West Yorkshire we were the first area nationally to adopt apprenticeships for the advanced clinical practitioner role which has been very beneficial. People who have come in from different sectors, i.e., pharmacists etc have been able to learn new skills and become advanced clinical practitioners which has been useful to place in settings where they can take the burden off other teams. Rob Webster confirmed that a networked model enables people to work in different trusts.

- Councillor Rhodes commented on the people plan and advised that she had heard the word strategies and vision for many years now however had not seen any outcomes. She wondered why it was being revisited again when it was agreed at a Bradford meeting three years ago that a workforce development sub-committee would be set up to look at the future, she asked what had happened to that? She emphasised how she had no confidence left in anything and the worries were around retention, the recruitment into retention, shortages in staff and midwifery sector struggling. She advised that currently student nurses were working above and beyond to cover staff shortages in hospitals. Councillor Rhodes expressed her views on the current system and wanted to know how will the focus change? She advised she did not want to hear jargon; she wants to see it happen. In response, Officers advised that they had the same view and approach as Councillor Rhodes; things needed to be done. Over the last 18 months, we have seen a much stronger focus on the daily needs of the staff. Providing people with Christmas bonuses and extra leave, and to give them a sense of belonging was important. There is a recruitment programme, which works across the mental health providers, also virtual recruitment fairs were undertaken which targeted different people and visiting of schools and colleges, telling them there are jobs available in the NHS. This needs to continue and staff need to be valued. Staff have been faced with really difficult circumstances. A lot of positive work has been done however this needs to continue. Officer also advised that local people were recruited at Red Kite View which opened in Leeds which has been a successful approach.

- Councillor Swift commented that the report doesn't mention trade unions anywhere. In response, Officers advised that they had a very constructive partnership with the area partnership group who had been on this journey with them. They also work together on other workforce issues. Councillor Swift commented that there was no reference of this in the report, suggested that the meetings they had, nothing much came out of it? In response, Officers advised that the report did mention workforce representatives and confirmed they had been part of the engagement on this.

- Councillor Hutchinson commented on the comment made by Rob Webster, on the need to retain staff. He further advised that under staffing is one of the major drives for people leaving the job. People are unable to do their job because there aren't enough staff to do it. He suggested that having a plan will address this and make it better. Moving staff around due to shortages will not help. Community

nursing is an area which needs to be addressed. Patient passports will not help. In response, Officers advised that work is being done with the workforce around community health services and more integration with primary care. Also, looking at new opportunities and roles. Officers advised that they are also looking at nurse recruitment and is being taken seriously. Digital staff passports were brought in a responded to dealing with the pandemic where staff were deployed to care within other systems. The digital staff passports allow us to deploy staff to areas where needed. Councillor Hutchinson suggested that the Queens Nursing institute should be invited to attend the Joint Committee along with the Royal College of Nursing.

- Councillor Smaje agreed with the comments made by Councillors Hutchinson and Rhodes, and further advised that if the workforce is not right, then the patients will have to be moving. She also mentioned that staff cannot continue to work at the pace they had been working on which is why recruitment was so important. Councillor Smaje suggested the Board have a meeting on addressing this plan as one item and to discuss this in more depth. The Chair agreed and advised that this would be arranged.

IT WAS AGREED that the report be noted.

16 NIGHTINGALE HOSPITAL

The working group considering the Nightingale Hospital had a very helpful discussion with Steve Russell and his colleagues, who answered many of the queries that Members had. The notes of that meeting are attached to the report as Appendix 1.

Members of the working group wish to feed the following recommendations into the national review of the response to the pandemic that the Government will arrange in 2022.

- To adopt this report of the working group
- To forward this report to the Secretary of State for Health and Social Care and to the Chief Executive of NHS England.
- To ask NHS England to undertake a national review of intensive care capacity in the country's hospitals
- To ask the West Yorkshire and Harrogate Health and Care Partnership to undertake an urgent review of oxygen capacity in West Yorkshire's acute hospitals.
- To thank the Chief Executive of Harrogate District hospitals NHS Trust and his colleagues for their excellent presentation, and responses to all the questions of Members of this Joint Committee

It is a tribute to the work of the NHS, local authorities, the community and voluntary sector and many others that we did not need to use the Nightingale Hospital.

Although we learnt that staffing the Nightingale hospital would have only required 0.6% of the NHS hospital workforce across Yorkshire and the Humber, this only worked when nearly all elective hospital work had been suspended. This still feels like it would be very "tight" and would have put significant pressure on certain key professions that would need to provide a safe level of cover in all hospitals and the Nightingale Hospital.

Councillor Clark thanked the committee for looking at this and stated the meeting with Steve Russell and colleagues was very useful and informative.

Councillor Hutchinson suggested that the possible causes of action are to be followed as outlined in the report, in particular asking for a national review of the intensive care capacity including staffing in the country's hospitals and to have an urgent review on oxygen capacity in West Yorkshire acute hospitals. Councillor Smaje agreed with comments made by Councillors Clark and Hutchinson.

The response to the Secretary of State should include an offer for the Committee to give evidence to the national enquiry.

IT WAS AGREED that:

(a) the recommendations be agreed; and

(b) the report to be forwarded to the Secretary of State for Health and Social Care and the Chief Executive of NHS England and ask them to consider this report in the detailed review that will be taken in response of the pandemic in 2022

17 WORK PLAN AND NEXT STEPS

The Senior Scrutiny Officer, Calderdale Council suggested that Members may wish to consider any items they wished to discuss at future meetings for inclusion in the work programme.

Following the earlier discussion on governance it was proposed that Mike Lodge, Senior Scrutiny Officer (Calderdale Council) arrange a meeting for the Chair and with Ian Holmes (West Yorkshire and Harrogate Health and Care Partnership), to look at timescales for further discussion.

A request had been made by Bradford Council to take a wider look at Dentistry Services across West Yorkshire, and Members agreed that work should be undertaken to pull this item together.

Councillor Hutchinson commented on the future workforce plan and the need to assure 'buy-in' from providers in order to support this work moving forward. He commented on the previous work which had been undertaken and the challenges this had presented. There was a need to look at how the workforce plan, at a West Yorkshire level, should be incorporated to the new ways of working (as outlined in the meeting today) and how scrutiny can best use its powers to encourage organisations to focus more closely on this issue. Members agreed that this item would be brought to a future meeting of this Committee.

IT WAS AGREED that the Senior Scrutiny Officer would develop the work plan in line with comments made at this meeting and scheduled future meeting dates which would be shared with the West Yorkshire Joint Health Overview Scrutiny Committee.

West Yorkshire Health and Care Partnership

West Yorkshire Joint Overview and Scrutiny Committee

29 March 2022

Summary report	
Item No:	
Item:	**West Yorkshire Integrated Care Board – constitution and governance**
Report author:	Stephen Gregg, Governance Lead, WY Health and Care Partnership
Presenter:	Stephen Gregg, Governance Lead, WY Health and Care Partnership

Executive summary

From 1 July 2022, subject to legislation, Integrated Care Boards (ICBs) will take on the commissioning responsibilities of Clinical Commissioning Groups and lead the integration of health and care services across their area. On 30 November 2021, we presented to the Joint Overview and Scrutiny Committee the draft constitution of the West Yorkshire ICB and supporting governance documents. This formed part of wider stakeholder involvement from 8 November 2021 to 14 January 2022. A summary of the feedback, including the changes that we have made in response, is attached at **Annex 1.** The amended draft constitution is attached at **Annex 2**.

The constitution and attached documents focus on the ICB's formal governance and decision-making. Key to this is delegation to our places. Feedback from involvement highlighted the need for our governance handbook to cover the wider partnership collaborative arrangements that will inform ICB decision-making, in particular the role of Health and Wellbeing Boards and the integrated care partnership (our existing Partnership Board) in setting strategy and the role of provider collaboratives in partnership working at place and system level. In response to this feedback, we are developing case studies which will include decision making across both places and ICS footprints. Key elements of the handbook are attached:

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

The constitution and all of our detailed arrangements remain in draft. They are subject to legislation, regulations (in particular in relation to the appointment of partner members of the board), and guidance from NHS England. A further version of the model ICB constitution is expected to be issued on 31st March and we will need to reflect the amendments in our constitution. To ensure that we can establish the ICB as a statutory organisation from 1 July, and to comply with national recruitment processes, we have already confirmed several designate appointments and are progressing with the appointment process for other posts.

Recommendations
The Joint Overview and Scrutiny Committee is recommended to: a) comment on the key messages from stakeholder involvement on the constitution, the amended draft constitution and draft supporting documents. b) note that the constitution remains in draft and is subject to legislation and regulations and that work is ongoing to further develop our governance handbook.

Background

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

The draft ICB constitution

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

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

4. The feedback was constructive and covered a wide range of areas. The issues receiving most responses were:
    - the size and composition of the ICB Board
    - the arrangements for delegating the ICBs functions to our places
    - public and patient involvement in our ICS.

5. Some of the main changes that we have made to the constitution include:

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

6. Other important comments were received which we will reflect in the governance handbook. These include:

    - setting out the key role of Health and Wellbeing Boards in setting strategy

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

7. Involvement on the constitution was complemented by a series of governance scenario workshops with partners which highlighted some important areas for further work including:

    - Collaborative behaviours and relationships are as important as formal governance structures at both place and WY level.
    - Decisions must be taken as close to local as possible, retaining the principle that ICB is the servant of place. We need to be clear on when we need to work across a wider footprint, the escalation mechanisms and how and by whom these decisions are taken.
    - The arrangements are complex and confusing. We need to describe them in plain language and communicate how they fit together.
    - Wherever possible, we should streamline formal governance and avoid layers of bureaucracy and duplication.
    - More work needed on what mutual accountability means in practice, how it relates to the accountability of individual organisations and what happens when difficult decisions need to be taken at place and WY level.

    A summary of the key issues raised during the involvement period and our response is attached at Annex 1.

The ICB Board

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

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

9. The revised proposed membership of the Board is:

Proposed WY ICB Board	Minimum national requirement
Independent perspective • Chair • 4 Independent Non-Executive members	• Chair • 2 Non-Executive directors
Healthwatch perspective • Healthwatch	• No requirement
Place perspective • 5 Place members • Local authority	• No requirement • 1 local authority.
Provider perspectives • Acute provider • Mental health, learning disability and autism provider • Community provider • Primary medical services • Voluntary, community and social enterprise sector	One member drawn from • NHS trusts and foundation trusts • primary medical services (general practice) providers
Public health perspective • Director of Public Health	• No requirement
System executive, clinical and professional • Chief Executive • Director of Finance • Director of Nursing • Medical Director • Director of People • Director of Strategy and Partnerships	• Chief Executive • Director of Finance • Director of Nursing • Medical Director • No requirement • No requirement
Total Board: 24	10

10. Appointments to several Board-level ICB roles have recently been announced and recruitment is underway to the Independent Non-Executive Member (INEM) roles. We are awaiting national guidance on aspects of the nomination process for partner members, which cannot be started until the partner member regulations become law.

11. All nomination and appointment processes include a requirement to have regard to the Partnership's commitment to improving the diversity of its leadership and to ensuring a spread of representation from across our places.

Committees of the ICB

12. Each of our places is establishing an ICB committee to take decisions about ICB functions and resources and is currently recruiting to independent roles on these committees. To ensure that the committees align with wider place partnership arrangements, alongside their formal title as ICB committee they are adopting place partnership naming conventions, for example: Calderdale Cares Partnership Board.

13. In addition to place committees, West Yorkshire-level committees are proposed to support the ICB Board in carrying out its functions and ensure that decision-making is transparent, with clear accountability. Except for the Audit and Remuneration Committees, all meetings will be held in public. The proposed committee structure is:

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

14. We are currently developing terms of reference for these committees. One of our governance design principles is to streamline our arrangements, avoiding duplication where possible. The move to new ICB arrangements will mean a significant reduction in some committees – for example rather than an Audit Committee and Remuneration Committee in each CCG, there will be single ICB committees for each.

The Integrated Care Partnership and wider decision-making

15. The formal ICB committee decision-taking structure will be only part of our inclusive partnership decision-making infrastructure. The Partnership Board will become our Integrated Care Partnership and set the system strategy. The Partnership Board will be a joint committee of the ICB and local authorities and will not be able to be formally established until the ICB is established in July. We are liaising with local authority governance colleagues over the arrangements for formally establishing the ICP. Until the ICP is formally established, it is proposed that the Partnership Board continues to meet in its current form.

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

Shadow operation

17. The delay in the Health and Care Act provides an opportunity for us to test our arrangements during a period of shadow operation. We have already established a Shadow Remuneration and Nomination Committee to make recommendations on senior executive and non-executive pay. As recruitment to ICB Board roles progresses, we will be in a position by April 2022 to establish our shadow Board and committees. We are developing a high level 'flight path', setting out key milestones in the development of shadow working.

18. We recognise that all our governance arrangements will remain in development after 1 July and will need to be reviewed and adapted as they bed in. Formal review at 12 and 18 months will be built into all aspects of the arrangements.

Timeline

19. The revised timeline for developing our governance arrangements is:

Action	Timeline
Draft ICB constitution co-produced by ICS Governance Working Group	Sept/Oct 2021
Draft communication and involvement plan coproduced with local place engagement leads with input from local place governance leads.	Sept / Oct 2021
CCGs agree partnership approach to involvement	Oct 2021
Preparation and planning for involvement	Sept / Oct 2021
Draft constitution to Partnership senior leaders for comment.	2 Nov 2021
Draft co-produced ICB constitution ready for involvement (subject to publication of national guidance)	8 Nov 2021
Involvement with all key stakeholders 'goes live' To include presentation to local OSCs and JHOSC.	8 Nov to 14 Jan 2022
Present draft constitution at WY&H HCP Partnership Board	7 Dec 2021
Collation of comments and suggestions about the constitution	Nov to Jan 2022
Draft constitution to NHS England for review and comment	December 2021
Feedback incorporated into draft constitution	Feb 2022
Revised draft constitution presented to Partnership Board.	1 March 2022
Final draft constitution and governance handbook 'work in progress' presented to Shadow ICB Board	April 2022
Shadow operation	April – end June
Final draft constitution and governance handbook to NHS England.	27 May 2022
Final draft constitution and governance handbook to Partnership Board	7 June 2022

Constitution comes into being with creation of ICB	1 July 2022

Recommendations

The Joint Overview and Scrutiny Committee is recommended to:

a) comment on the key messages from stakeholder involvement on the constitution, the amended draft constitution and draft supporting documents.
b) note that the constitution remains in draft and is subject to legislation and regulations and that work is ongoing to further develop our governance handbook.

Stephen Gregg
Governance Lead
West Yorkshire and Harrogate Health and Care Partnership

Annex 1

Draft West Yorkshire Integrated Care Board constitution

Report on responses to involvement

Introduction

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

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

Approach to involvement

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

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

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

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

Responses to the engagement

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

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

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

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

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

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

Summary

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

Responses were received from:

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

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

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

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

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

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

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

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

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

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

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

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

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

NHS West Yorkshire Integrated Care Board Constitution: Draft V 0.4

Notes

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

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

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

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

[Insert ICB logo]

NHS West Yorkshire Integrated Care Board

Part of the West Yorkshire Health and Care Partnership

CONSTITUTION

CONTENTS

1. Introduction

1.1 Background/ Foreword

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

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

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

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

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

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

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

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

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

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

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

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

,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.2 Name

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

1.3 Area Covered by the Integrated Care Board

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

1.4 Statutory Framework

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

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

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

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29). This constitution is published at [Add web address]

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

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

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

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

a) section 14Z34 (improvement in quality of services),
b) section 14Z35 (reducing inequalities),

c) section 14Z38 (obtaining appropriate advice),
d) section 14Z43 (duty to have regard to effect of decisions)
e) section 14Z44 (public involvement and consultation),
f) sections 223GB to 223N (financial duties), and
g) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z58 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z59).

1.5 Status of this Constitution

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

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

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

1.6 Variation of this Constitution

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

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

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

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

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

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

1.7 Related Documents

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

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

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

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

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

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

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

d) The ICB Governance Handbook[2]– which includes:

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

[2] The Governance Handbook will be published separately.

to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.

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

e) Key policy documents[3] - including:

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

[3] Key policy documents are currently under development.

2. Composition of The Board of the ICB

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

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

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

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

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

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

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

b) At least two independent non-executive members

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

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

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

Board Membership

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

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

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

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

2.8 The board is therefore composed of the following members:

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

Regular Participants and Observers at Board Meetings

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

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

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

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

3. Appointments Process for the Board[4]

3.1 Eligibility Criteria for Board Membership:

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test"
b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles)
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.
d) Commit to behave consistently as leaders and colleagues in ways which model and promote the shared values set out in paragraph 1.1.21.

3.2 Disqualification Criteria for Board Membership

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

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

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

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

a) in the United Kingdom of any offence, or
b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.5 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, sections 56A to 56K of the Bankruptcy (Scotland) Act 1985 or Schedule 2A

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

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

3.2.6 A person who, has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.7 A person whose term of appointment as the chair, a member, a director or a governor of a health service body, has been terminated on the grounds:

a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office
b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings,
c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest, or
d) of misbehaviour, misconduct or failure to carry out the person's duties;

3.2.8 A health care professional (within the meaning of section 14N of the 2006 Act) or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was—

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
b) the person's erasure from such a register, where the person has not been restored to the register
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.9 A person who is subject to—

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

3.2.10 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

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

a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or
b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

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

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

a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

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

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

3.4 Chief Executive

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

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

3.4.3 The Chief Executive must fulfil the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act

3.4.4 Individuals will not be eligible if

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

3.5 Partner Members - NHS Trusts and Foundation Trusts

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

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

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

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

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

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

3.5.3 Individuals will not be eligible if

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

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

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

3.5.5 The appointment process will be as follows:

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

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

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

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

3.6 Partner Member - Providers of Primary Medical Services.

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

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

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

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

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

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

3.6.3 Individuals will not be eligible if:

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

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

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

3.6.5 The appointment process will be as follows:

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

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

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

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

3.7 Partner Member - local authorities

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

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

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

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

3.7.3 Individuals will not be eligible if

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

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

3.7.5 The appointment process will be as follows:

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

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

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

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

3.8 Medical Director

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act

b) Be a registered Medical Practitioner

3.8.2 Individuals will not be eligible if:

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

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

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

3.8.4 The appointment process will be as follows:

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

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

3.9 Director of Nursing

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act

b) Be a registered Nurse

3.9.2 Individuals will not be eligible if:

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

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

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

3.9.4 The appointment process will be as follows:

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

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

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

3.10 Director of Finance

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act
b) Be a qualified accountant.

3.10.2 Individuals will not be eligible if:

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

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

3.10.4 The appointment process will be as follows:

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

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

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

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

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

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

3.11.4 Individuals will not be eligible if

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

3.11.5 The appointment process will be as follows:

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

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

3.11.7 Initial appointments may be for a shorter period in order to avoid all non-executive members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.

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

3.12 Other board members

3.13 Five Members – Place-based Partnerships

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

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

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

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

3.13.3 Individuals will not be eligible if

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

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

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

3.13.6 The appointment process will be as follows:

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

3.14 Member - Director of Public Health

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

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

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

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

3.14.3 Individuals will not be eligible if

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

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

3.14.5 The appointment process will be as follows:

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

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

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

3.15 Member – community services

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

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

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

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

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

3.15.3 Individuals will not be eligible if

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

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

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

3.15.5 The appointment process will be as follows:

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

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

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

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

3.16 Member - Voluntary, community and social enterprise sector

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

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

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

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

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

3.16.3 Individuals will not be eligible if

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

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

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

3.16.5 The appointment process will be as follows:

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

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

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

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

3.17 Member - Healthwatch

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

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

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

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

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

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

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

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

3.18 Director of People

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act

3.18.2 Individuals will not be eligible if:

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

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

3.18.4 The appointment process will be as follows:

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

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

3.19 Director of Strategy and Partnerships

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act.

3.19.2 Individuals will not be eligible if:

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

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

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

3.19.4 The appointment process will be as follows:

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

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

3.20 Board Members: Removal from Office.

3.20.1 Arrangements for the removal from office of Board members is subject to the term of appointment, and application of the relevant ICB policies and procedures.

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

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this constitution, regulations or guidance
b) If they fail to attend three consecutive meetings unless agreed with the Chair in extenuating circumstances
c) If they are deemed to not meet the expected standards of performance at their annual appraisal.
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to failing to meet the ICB standards of business conduct; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a

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

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

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

3.20.4 Executive Directors (including the Chief Executive) will cease to be Board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

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

3.20.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

a) terminate the appointment of the ICB's chief executive; and
b) direct the chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.21 Terms of Appointment of Board Members

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

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

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

3.22 Specific arrangements for appointment of Ordinary Members made at establishment

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

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

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

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

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

3.23 Review of Board size and composition

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

4. Arrangements for the Exercise of our Functions.

4.1 Good Governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.

4.1.2 The ICB has agreed a Standards of Business Conduct policy which sets out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of governance standards and principles that will guide decision making in the ICB. The ICB code of conduct, governance standards and behaviours are published in the Governance Handbook.

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

4.2 General

4.2.1 The ICB will:

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

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(e) above, documenting them as necessary in this constitution, its governance handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) any of its members or employees
b) a committee or sub-committee of the ICB

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

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

4.4 Scheme of Reservation and Delegation

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

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

4.4.3 The SoRD sets out:

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

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

4.5 Functions and Decision Map

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

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

4.5.3 The map includes:

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

4.6 Committees and Sub-Committees

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

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

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

4.6.4 The Board remains accountable for all functions, including those that it has delegated to committees and subcommittees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub committees that fulfil delegated functions of the ICB, will be required to:

[5] Under development.

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

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

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

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

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

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

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

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

i) demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity

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

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

4.6.6 All members of committees and sub-committees are required to act in accordance with this constitution, including the standing orders as well at the SFIs and any other relevant ICB policy.

4.6.7 The following committees will be maintained:

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

The Audit Committee will be chaired by an independent non-executive member (other than the Chair of the ICB) who has the qualifications,

expertise or experience to enable them to express credible opinions on finance and audit matters.

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

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

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

4.6.9 The Board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

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

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

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

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

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

5. Procedures for Making Decisions

5.1 Standing Orders

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

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

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

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

5.2 Standing Financial Instructions (SFIs)[6]

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

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

[6] Standing Financial Instructions are under development.

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

6.1 Conflicts of Interest

[Subject to change in line with NHS England guidance]

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

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

6.1.3 All Board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of interest Policy and the Standards of Business Conduct Policy.

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

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
c) Support the rigorous application of conflict of interest principles and policies;

d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

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

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

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

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

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

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

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

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

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

c) Its employees

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

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

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared and discussed on appointment and during relevant discussion in meetings.

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

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

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

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of Business Conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) act in good faith and in the interests of the ICB;
b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);
c) comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

7. Arrangements for ensuring Accountability and Transparency

7.0 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 11(2) of Schedule 1B to the 2006 Act.

7.1 Principles

7.1.1 We will

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

7.2 Meetings and publications

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

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

7.2.3 Annual accounts will be externally audited and published.

7.2.4 A clear complaints process will be published.

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

7.2.6 information will be provided to NHS England as required.

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

a) Conflicts of interest policy and procedures
b) Registers of interests
c) Standards of Business Conduct

7.2.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

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

And

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

7.3 Scrutiny and Decision Making

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

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

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

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

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

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

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

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

7.4 Annual Report

7.4.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year and in particular how it has discharged its duties under sections

- 14Z34 (improvement in quality of services),
- 14Z35 (reducing inequalities),
- 14z43 (have regard to the effect of decisions)
- 14Z44 (public involvement and consultation), and

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

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

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

7.4.3 Review any steps the board has taken to implement any joint health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

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

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

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

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

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

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

8.6 The duties of the Remuneration and Nomination Committee include:

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

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

9. Arrangements for Public Involvement

9.1 In line with section 14Z44(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) the planning of the commissioning arrangements by the Integrated Care Board
b) the development and consideration of proposals by the ICB
c) for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them, and
d) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.2 In line with section 14Z52 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

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

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

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.
c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is working.
d) Build relationships with excluded groups – especially those affected by inequalities.
e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.
f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this constitution
Board (ICB Board)	The decision-making body of the ICB at West Yorkshire level.
Committee	A committee created and appointed by the ICB Board.
Health and Wellbeing Board	A statutory committee of a local authority (at place level) which brings together leaders from the local health and care system. Responsible for producing a joint strategic needs assessment and a joint health and wellbeing strategy.
Health Overview and Scrutiny Committee	A statutory committee of a local authority that undertakes in-depth reviews of health and care issues for local people. There are overview and scrutiny committees at place and West Yorkshire level.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
Integrated Care Partnership (ICP)	The joint committee of the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Integrated Care System (ICS)	The whole health and care system across West Yorkshire known as the West Yorkshire Health and Care Partnership. The ICS is made up of the NHS, councils, Healthwatch and the voluntary, community and social enterprise sector (VCSE) partners in each of our places (Bradford District and Craven; Calderdale, Kirklees, Leeds and Wakefield) and across West Yorkshire.
Partnership	The West Yorkshire Health & Care Partnership (the ICS).

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

Appendix 2: Standing Orders

1. Introduction

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

2. Amendment and review

2.1 The Standing Orders are effective from xx

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

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

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

3. Interpretation, application and compliance

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

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

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

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

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

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

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

4. Meetings of the Integrated Care Board

4.1 Calling Board Meetings

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

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

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

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

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

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

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

4.2 Chair of a meeting

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

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

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

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

4.3 Agenda, supporting papers and business to be transacted

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

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

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

4.4 Petitions

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

4.5 Nominated Deputies

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

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

4.6 Virtual attendance at meetings

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

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

4.7 Quorum

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

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

4.7.2 For the sake of clarity:

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

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

4.8 Vacancies and defects in appointments

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

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

4.9 Decision making

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

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

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

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

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

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

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

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

<u>Disputes</u>

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

<u>Urgent decisions</u>

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

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

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

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

4.10 Minutes

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

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

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

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

4.11 Admission of public and the press

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

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

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

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

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

5. Suspension of Standing Orders

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

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

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

6. Use of seal and authorisation of documents.

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

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

Annex 3

West Yorkshire Integrated Care Board - Governance handbook

DRAFT summary of contents

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[8] *As recommended by Digital Board*

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

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

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

[10] *As above.*

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

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

West Yorkshire Integrated Care Board
functions and decisions map

Annex 5

West Yorkshire Health and Care Partnership

West Yorkshire Integrated Care Partnership(ICP)

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

Strategy

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

- agree health and wellbeing strategy for each Place

Strategy

Strategy

West Yorkshire Integrated Care Board(ICB)

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

Delivery

Delegation

Accountability

Place-based committees of the ICB

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

Delegation

Assurance

ICB Committees

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

Delegation

Assurance

ICB Place Sub Committees

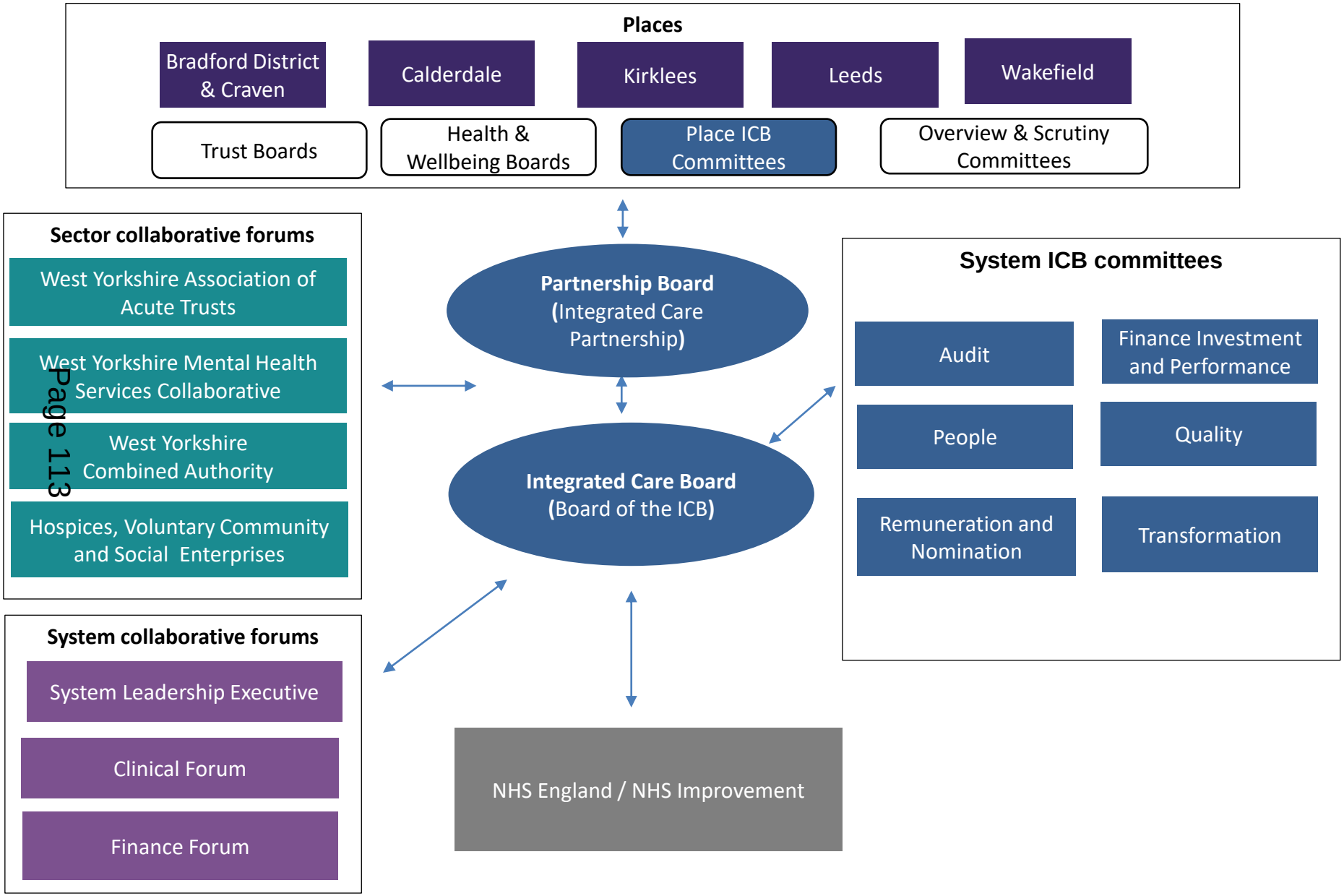
- provide the Place-based Committee with assurance about Place delegated functions e.g. quality, finance

Strategy and delivery supported and informed by collaborative forums

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

West Yorkshire Integrated Care System - Governance and accountability

Annex 6



West Yorkshire Health and Care Partnership DRAFT ICS Governance standards

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

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

West Yorkshire Mental Health, Learning Disability and Autism Collaborative

Joint Health Overview & Scrutiny Committee – 29th March 2022

Keir Shillaker

The purpose of this pack is to describe:

- The overall operating model for Mental Health, Learning Disability and Autism (MHLDA) in West Yorkshire
- The role of the MHLDA collaborative and its governance as part of the West Yorkshire operating model
- Examples of some areas of work being taken forward at West Yorkshire level, and the interface between the place, system and the Collaborative:
    - Children & Young People's Mental Health
    - Suicide Prevention
    - Neurodiversity
    - Psychiatric Intensive Care (PICU)
    - Community Mental Health Transformation

The MHLDA function of the Integrated Care Board

- To **support transformation of agreed WY strategic priorities** for MHLDA, in close partnership with the MHLDA collaborative

- To **ensure delivery of the Long-Term Plan** and the Partnership ambition to **reduce the gap in life expectancy** between people with mental illness, learning disability and autism and the rest of the population

- To ensure **delivery of Mental Health Investment Standard** requirements at system and in each place.

- To ensure appropriate discharge of **statutory responsibilities** in each place: such as the Mental Capacity Act, Section 117 duty to work with local authorities to provide or arrange for provision of aftercare post hospital and Section 140 duty to identify placements for people who urgently need admission.

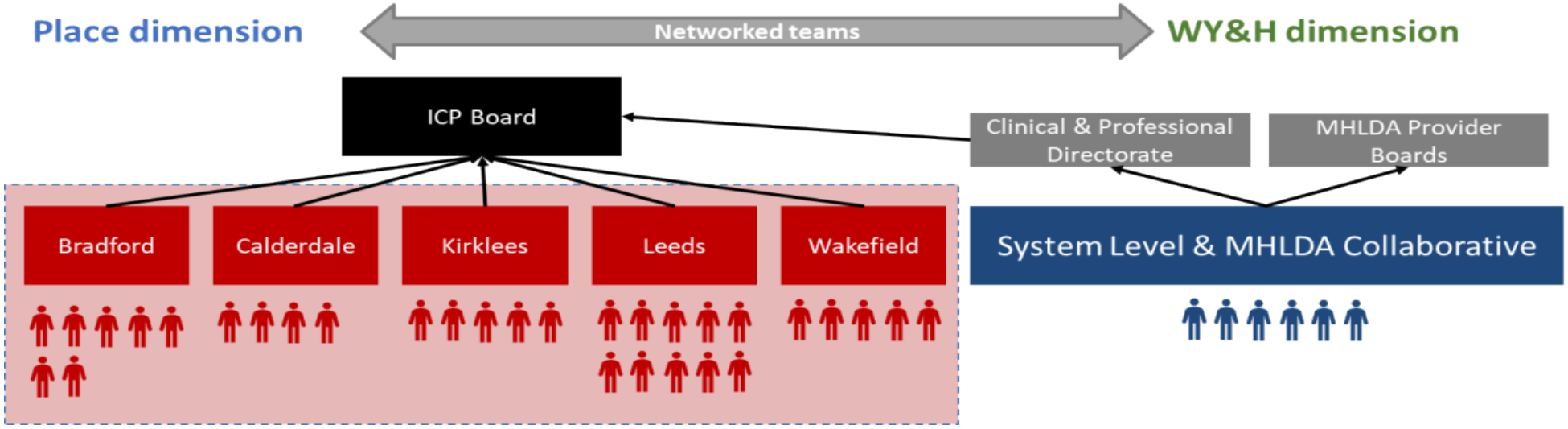
Primacy of place in MHLDA

- Each **place-based partnership** within West Yorkshire remains the main vehicle for local discussions on service change & transformation regarding MHLDA. **Place-based leaders, VCSE organization from each place and NHS Trusts all represented on WY MHLDA Partnership Board**.

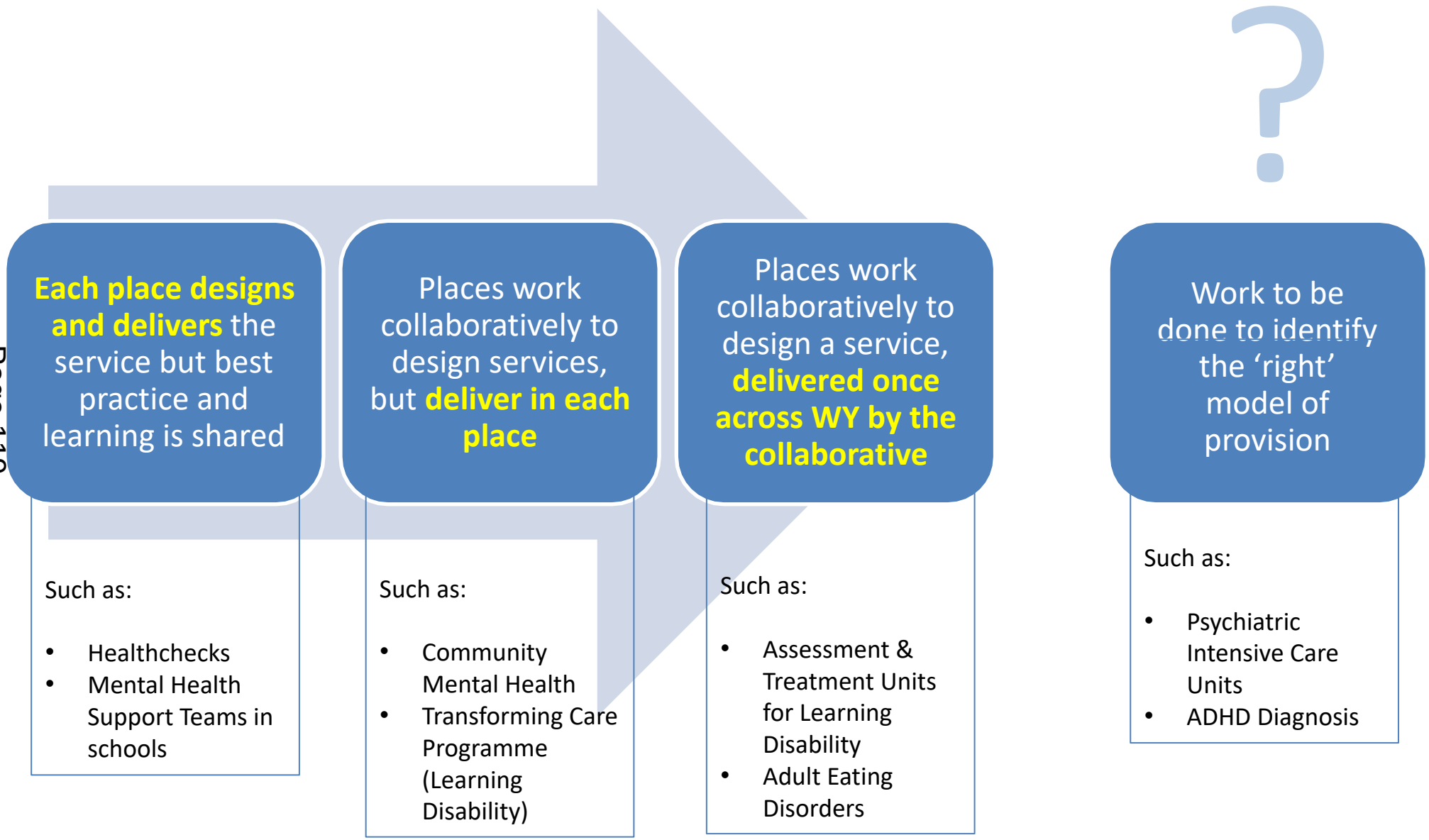
- The vast majority of **capacity is retained in place**, with some retained at system level (* diagram representative - not accurate to headcount!)

- Places lead local work and **share the responsibility** for leading and supporting various elements of West Yorkshire wide work

- West Yorkshire wide 'system' capacity and MHLDA Collaborative capacity is the **same resource**

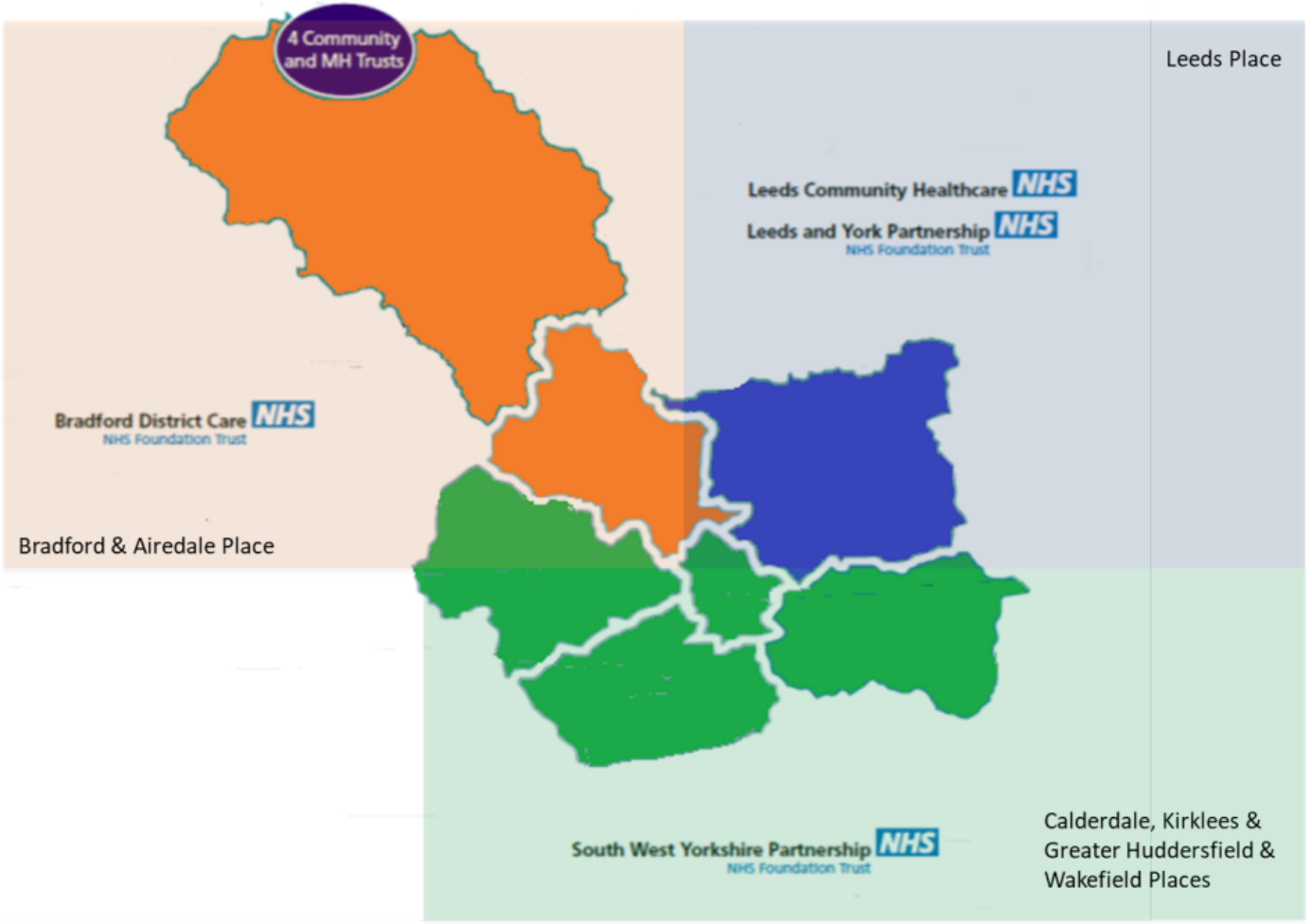


Design and delivery of services at different levels



The MHLDA Collaborative

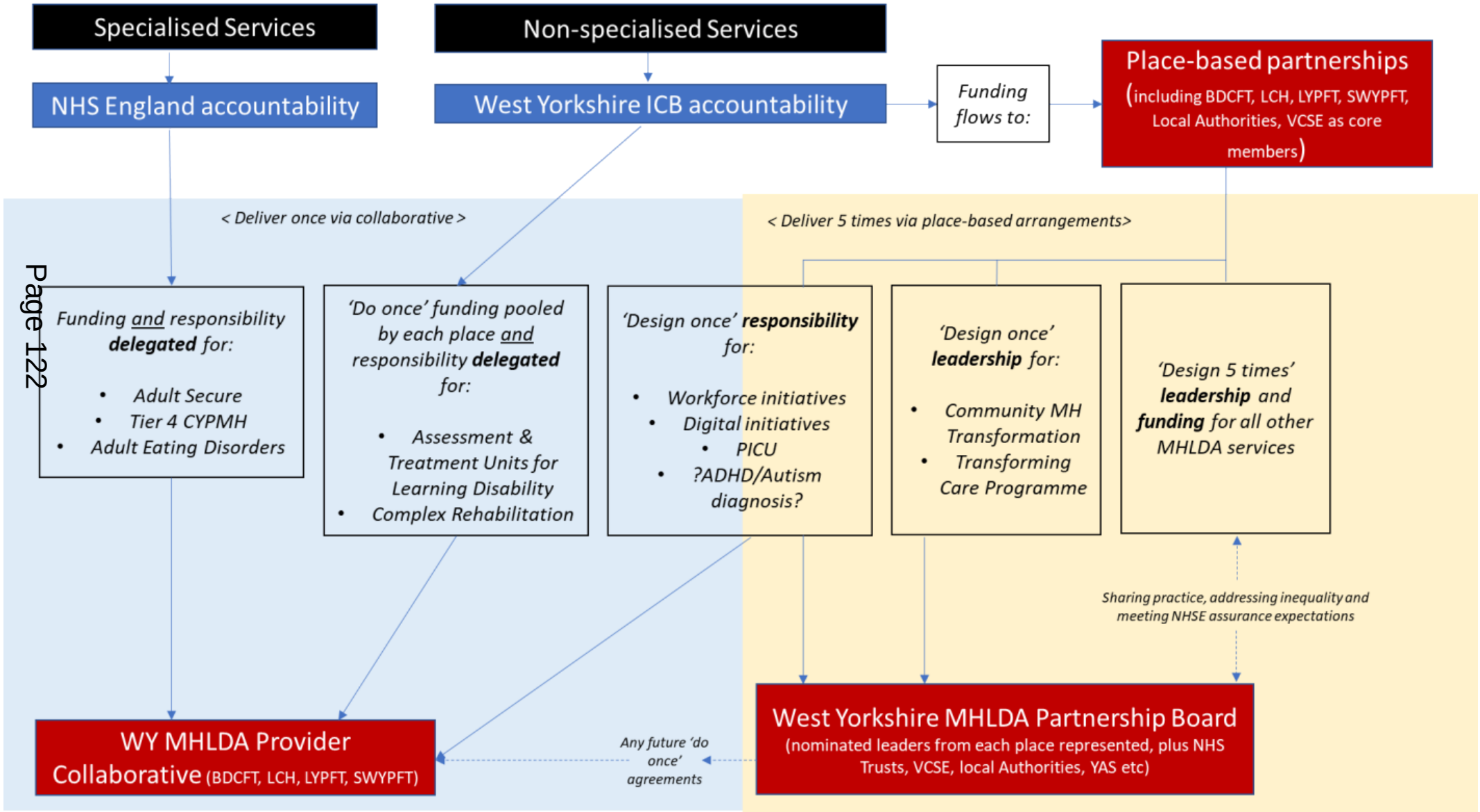
- Four NHS Trusts
- Formal ‘Committees in Common’ of the Trust Boards meets every quarter
- Twice-yearly Non-Executive and Governor event
- Informal ‘mutual aid’ and operational support via Chief Operating Officers and regular discussions with other execs



The MHLDA Collaborative (2)

- The MHLDA provider collaborative will be the main vehicle for significant service change and **transformation at scale**, by:
    - **Leading 'do once' and 'design once' priorities** through the core team and constituent members (NHS Trusts) on behalf of partners.
    - Taking responsibility for **commissioning and provision of specialized services and some commissioned services** (with accountability and direction remaining with the respective Executive Director for Commissioning in the Lead Provider Trust)
    - Playing a **critical leadership role in visibility of the MHLDA agenda across the ICB**, including assurance and sharing of good practice
    - Identifying and leading **bespoke projects at the request of the ICB**
    - **Supporting the establishment of strong place-based partnership arrangements** across the Trusts, VCSE, local authorities and primary care

How the governance works



How the governance works – ‘bitesized’ case studies

Children and Young People’s Inpatient (Tier 4) services are a specialised commissioning service, with funding and accountability delegated to the MHLDA Collaborative by NHS England, through LYPFT as the lead provider

Assessment & Treatment Units for Learning Disability are a non-specialised commissioned service, provided by BDCFT and SWYPFT with funding received by the ICB. Each place agrees to pool their allocation and pass through to the MHLDA Collaborative, through BDCFT as the lead provider

Psychiatric Intensive Care Units are non-specialised commissioned services, provided by LYPFT, BDCFT and SWYPFT, with funding received by the ICB and allocation flows to each place-based partnership, which retains responsibility for their local PICU. However leadership to improve consistency of the PICU operating model and reduce reliance on out of area placements rests with the MHLDA Collaborative.

Community Mental Health is locally commissioned by each place-based partnership, with funding received by the ICB, any ‘do once’ elements agreed by places and pooled at West Yorkshire level and discharged through the WY MHLDA Partnership Board. But the majority of funding and the responsibility flows to each place-based partnership.

IAPT is locally commissioned by each place-based partnership, with funding received by the ICB and flows to those place-based partnerships. Shared learning on IAPT models, future discussion on ‘do once’ opportunities and understanding of system performance is discharged as a communication between place-based partnerships and the WY MHLDA Partnership Board. But overall responsibility rests with the place-based partnerships.

Some examples

Children & Young People's Mental Health

Overall summary: We have a co-produced WY CYPMH strategic plan* that wants to ensure '"Children and Young People from West Yorkshire can access mental health support easily and in a personalised way. If and when specialised mental health services are required there will be seamless integrated pathways in place across community and specialist provision, with trusted assessment processes which minimise delay in accessing the right level of support required. Services will be trauma informed, inclusive and skilled in supporting individuals with diverse needs (including neurodiversity and learning disability)".

Role of places:

- To design and deliver services for CYP with mental illness in each place, including:
  - Focus on prevention, early identification of need and proactive intervention
  - Design and deliver local CYP transformation plans
  - Ensure appropriate investment of MHIS resources
  - Delivery of Mental Health Support Teams

Role of system:

- Collective view on four priorities:
- 24/7 Crisis and Intensive Home Treatment Teams to reduce variation and ensure seamless community and inpatient care
- Eating Disorders – standardized offer and skilled workforce with the right capacity
- Neurodiversity – workforce skills, awareness and making it 'everyone's business'
- Transitions – personalized care with claity on roles and responsibilities

Role of MHLDA Collaborative:

- Delivery of inpatient services and pathways in/out of Red Kite View
- Influencing place-based investment to reduce reliance on inpatient provision
- Optimizing inpatient care to reduce out of area placements

*https://www.wypartnership.co.uk/application/files/2816/3793/2274/WY_CYP_MH_Strategic_Plan_MASTER_final.pdf

Suicide Prevention

Overall summary: We have a co-produced WY Suicide Prevention Strategy* that describes our work to influence, do, raise awareness and share. It describes the things that make sense to do at scale to reduce suicide rates but recognizes that responsibility for developing and delivering local plans to prevent suicide sit with the Directors of Public Health in each of our places.

Role of places:

- Develop local suicide prevention plans and Suicide Prevention Groups
- Work closely with Local Authority, VCSE and NHS representatives to invest in prevention activities and support infrastructure

Role of system:

- Support awareness raising to reduce stigma and bring together wide range of partners including embedding coproduction
- Improve information sharing, including use of Real Time Surveillance data
- Provide NHSE funding to places to utilize and target specific system wide population groups for investment

Role of MHLDA Collaborative:

- Bring together the NHS Trusts to share learning from serious incidents
- Improve understanding of pathways between services for people who are suicidal, including those who are in crisis

*https://suicidepreventionwestyorkshire.co.uk/application/files/8516/4431/6977/Suicide_Prevention_Strategy_2022-2027.pdf

Neurodiversity

Overall summary: Each of our places currently designs and delivers their own Neurodiversity (Autism, ADHD) diagnostic pathways and supporting infrastructure. In the autumn it was agreed that more work should be done collectively to understand variation in current provision and any opportunities to do work once. We are undertaking a 'neurodiversity deep dive' to provide the data, information and co-production capacity to take some decisions on this as a system.

Role of places:

- To design and deliver services for people with Autism and ADHD in each place

Role of system:

- Undertake the Neurodiversity deep dive to identify opportunities for standardization, sharing of practice or 'do once' work. Including understanding the current experience of users and families. Mapping existing provision.

Role of MHLDA Collaborative:

- Depending on the results of the deep dive and other conversations, consider the potential for collaborative partners to work together in the delivery of new ways of working.

Psychiatric Intensive Care

Overall summary: We currently have three PICUs in West Yorkshire, each working independently as part of SWYPFT, BDCFT and LYPFT infrastructure. Each faces challenges with sending too many people out of area for treatment and we have recognized the opportunities to bring the operation of these units closer together, including modelling undertaken that shows how working in consistent and coherent ways may significantly reduce reliance on out of area beds

Role of places:

- To design and deliver PICU services for the local population

Role of system:

- Consider the commissioning implications of closer working/standardization of the PICUs as part of a review of potential operating models

Role of MHLDA Collaborative:

- Bring clinical and operational teams together to:
  - Develop and agree standardized pathways, including improvements in admission avoidance, length of stay and flow etc
- By, developing a standardized operating procedure, establishing a PICU clinical forum, developing a shared data dashboard and appointing a Senior Inpatient Oversight Lead to work across the collaborative

Community Mental Health Transformation

Overall summary: Significant investment is coming into West Yorkshire from NHSE to improve the service offer provided by Community MH Teams to adults in conjunction with primary care and VCSE partners. This includes a focus on eating disorders, rehabilitation, personality disorder, broader services for people with Severe Mental Illness and physical healthchecks, psychosis and employment. Most of the work is designed and delivered in each place with oversight across West Yorkshire.

Role of places:

- Ensure local services transform in line with NHSE requirements to deliver improved access to core CMH model
- Ensure partnership arrangements between primary care, NHS and VCSE are strong
- Address inequalities and systematically capture lived experience
- Increase use of ARRS (Additional Roles Reimbursement Scheme) in Mental Health within Primary Care

Role of system:

- Support oversight and development of collective outcomes framework and inequality framework
- Deliver 'do once' support on information governance and decision making in primary care
- Ensure collaborative decision making on funding allocations to each place

Role of MHLDA Collaborative:

- Deliver Complex Rehabilitation element of CMH transformation
- Ensure interface between CONNECT Eating Disorder service and place-based eating disorder teams

Thank you