NHS Dorset
Integrated Care Board

CONSTITUTION

Version	Date approved by the ICB	Effective date
V1.0	N/A	1 July 2022

CONTENTS

1 Introduction and Overview

1.1 Background/Foreword

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

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

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

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

1.2 Name

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

1.3 Area Covered by the Integrated Care Board

1.3.1 The areas covered by the ICB is the District of Bournemouth, Christchurch and Pool and the District of Dorset.

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 http://www.nhsdorset.nhs.uk/.

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

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

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

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

a) section 14Z34 (improvement in quality of services),
b) section 14Z35 (reducing inequalities),
c) section 14Z38 (obtaining appropriate advice),
d) section 14Z40 (duty in respect of research),
e) section 14Z43 (duty to have regard to effect of decisions).
f) section 14Z44 (public involvement and consultation),
g) sections 223GB to 223N (financial duties), and
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act), and to intervene where it is satisfied that the ICB is failing or has failed to discharge any of its functions, or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its constitution by reference to this document.

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

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

1.6 Variation of this Constitution

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

a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and
b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

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

a) Proposed amendments to this constitution may be submitted by the Chief Executive or the Chair to the Board for consideration and approval, prior to such amendments being 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 functions that are reserved to the board of the ICB and those functions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

b) **Functions and Decision Map**– a high-level structural chart that sets out where key ICB functions are. 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 ("the Governance Handbook")**– This brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:

- The above documents a) to c).
- Terms of reference for all committees and sub-committees of the Board that exercise ICB functions.
- Delegation arrangements for all instances where ICB functions are delegated, including in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other body duly prescribed in secondary legislation; or to a joint committee of the ICB and one 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 body duly prescribed in secondary legislation; or to a joint committee of the ICB and one or more of those organisations in accordance with section 65Z6 of the 2006 Act.
- The up-to-date list of eligible providers of primary medical services under clause 3.6.2.
- The Governance Handbook may also contain in Schedule form other documents relating to the ICS more generally.

e) **Key policy documents**– which should also be included in the Governance Handbook or linked to it - including the following, as amended, supplemented or updated from time-to-time by the Board:

- Standards of Business Conduct Policy;

- Conflicts of interest policy and procedures;
- Policy for public involvement and engagement; and
- Other documents as determined by the Chief Executive for inclusion within the Governance Handbook from time to time.

2 Composition of the Board of the ICB

2.1 Background

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

2.1.2 Further information about the individuals who fulfil these roles can be found on our website http://www.nhsdorset.nhs.uk/.

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

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

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

2.1.5 In line with the NHS England Policy requires the ICB to appoint the following additional Ordinary Members:

a) three executive members, namely:

- Chief Finance Officer
- Chief Medical Officer
- Chief Nursing Officer

b) At least two non-executive members.

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

- NHS trusts and NHS foundation trusts who provide services for the purposes of the health service 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 areas coincides with, or includes the whole or any part of, the ICB's area.

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

2.2 Board Membership

2.2.1 The ICB has six Partner Members.

a) Two from NHS and Foundation Trusts
b) Two from Primary Medical Services
c) Two from Local Authorities

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

a) Six non-executive members

2.2.3 The board is therefore composed of the following members:

a) Chair
b) Chief Executive
c) Two Partner Members – NHS and Foundation Trusts
d) Two Partner Members – Primary Medical Services
e) Two Partner Member – Local Authorities
f) Six non-executive members
g) Chief Finance Officer
h) Chief Medical Officer
i) Chief Nursing Officer

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

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

2.3 Participants at Board Meetings

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

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

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

3 Appointments Process for the Board

3.1 Eligibility Criteria for Board Membership:

3.1.1 Each member of the ICB must:

a) comply with the criteria of the “fit and proper person test”;
b) be 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 in the Governance Handbook.

3.2 Disqualification Criteria for Board Membership

3.2.1 A Member of Parliament.

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

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

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

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

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

3.2.6 A person whose term of appointment as the chair, a member, a director or a governor of a Health Service Body, has been terminated on the grounds:

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

3.2.7 A healthcare 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 out]'come of which was—

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

3.2.8 A person who is subject to:

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

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

3.2.10 A person who has, at any time, been removed or is suspended from the management or control of anybody 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 In addition to criteria specified in 3.2, individuals will not be eligible if:

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

3.3.4 The initial term of office for the Chair will be two years, with the following terms of office being three years. The Chair shall be eligible for reappointment but may not serve more than three consecutive terms or eight years in total, whichever is lesser.

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.

3.5 Partner Members — NHS Trusts and Foundation Trusts

3.5.1 These Partner Members are jointly nominated by the NHS Trusts and/or FTs which provide services for the purposes of the health service within the ICB's area and meet the forward plan condition or (if the forward plan condition is not met) the level of services provided condition:

a) Dorset County Hospital NHS Foundation Trust
b) Dorset Healthcare University NHS Foundation Trust
c) South Western Ambulance Service NHS Foundation Trust
d) University Hospitals Dorset NHS Foundation Trust

3.5.2 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 NHS Trusts or FTs within the ICB's area.

b) One member must have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

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

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

3.5.5 The appointment process will be as follows:

a) Joint Nomination:

(i) When a vacancy arises, each eligible Trust named at 3.5.1 will be invited to make one nomination.
(ii) The Trusts may nominate an individual from their own organisation or another organisation.
(iii) The Trusts will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below.

(iv) If there is no agreement, the nomination process will re-run until a consensus is reached on the nominations put forward.

b) Assessment, Selection and Appointment:

(i) The full list of nominees will be considered by an Appointments Panel convened by the Chief Executive.
(ii) The Appointments Panel will assess the suitability of the nominees against the requirements of the Role and Person Specification and will confirm that the nominees meet the requirements set out in clause 3.5.2 and 3.5.3
(iii) In the event that there is more than one suitable nominee, the Appointments Panel will select the most suitable for appointment.

c) Approval:

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

3.5.6 The term of office for this Partner Member will be for one term of three years duration, following which the partner organisations will be asked to nominate an individual, in accordance with the process set out in 3.5.5 above. An individual may be re-nominated for further terms of up to three years, provided that they continue to meet the eligibility criteria set out at 3.5.2 above.

3.6 Partner Members - Providers of Primary Medical Services

3.6.1 These Partner Members are jointly nominated by providers of Primary Medical Services for the purposes of the health service within the ICB's area, and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.

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

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

a) The member must be engaged to provide Primary Medical Services for at least two sessions a week.

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

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

3.6.6 The appointment process will be as follows:

Joint Nomination:

(i) When a vacancy arises, each Provider of Primary Medical Services listed in the Governance Handbook will be invited to make one nomination.
(ii) The Providers of Primary Medical Services may nominate an individual from their own organisation or another organisation.
(iii) The Providers of Primary Medical Services will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step (b) below.
(iv) If there is no agreement, the nomination process will re-run until a consensus is reached on the nominations put forward.

b) Assessment, Selection and Appointment:

(i) The full list of nominees will be considered by an Appointments Panel convened by the Chief Executive.
(ii) The Appointments Panel will assess the suitability of the nominees against the requirements of the Role and Person Specification and will confirm that the nominees meet the requirements set out in clause 3.6.3 and 3.6.4.
(iii) In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Approval:

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

3.6.7 The candidate approved for appointment will serve one term of three years, which may be renewed by the Board, with approval from the Chair. The maximum term any individual may serve is three consecutive terms or nine years, whichever is lesser. At the end of each term of office, the appointment process set out in 3.6.5 will be followed to re-affirm the incumbent postholder or nominate an alternative candidate.

3.7 Partner Members - local authorities

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

a) Bournemouth, Christchurch, and Poole Council

b) Dorset Council.

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

a) be the Chief Executive, hold a relevant Executive-level role or be an elected member of one of the bodies referred to at 3.7.1.

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

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

3.7.5 The appointment process will be as follows:

Joint Nomination:

(i) When a vacancy arises, the local authorities named at 3.7.1 will be invited to make one nomination.
(ii) The local authorities may nominate an individual from their own organisation or another organisation.
(iii) The local authorities will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. If there is no agreement, the nomination process will re-run until majority acceptance is reached on the nominations put forward. If they do agree, the list will be put forward to step b) below.
(iv) If there is no agreement, the nomination process will re-run until a consensus is reached on the nominations put forward.

b) Assessment, Selection and Appointment:

(i) The full list of nominees will be considered by an Appointments Panel convened by the Chief Executive.
(ii) The Appointments Panel will assess the suitability of the nominees against the requirements of the Role and Person Specification and will confirm that the nominees meet the requirements set out in clause 3.7.2 and 3.7.3.
(iii) In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Approval:

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

3.7.6 The candidates approved for appointment will serve one term of three years, which may be renewed by the Board, with approval from the Chair.

The maximum term any individual may serve is three consecutive terms or nine years, whichever is lesser. At the end of each term of office, the appointment process set out in 3.7.5 will be followed to re-affirm the incumbent postholder or nominate an alternative candidate.

3.8 Chief Medical Officer

3.8.1 This member will fulfil the eligibility criteria set out at 3.1.1 and also the following additional eligibility criteria.

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

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

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

3.9 Chief Nursing Officer

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 19(4)(b) of Schedule 1B to the 2006 Act; and
b) be a registered Nurse.

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

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

3.10 Chief Finance Officer

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

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

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

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

3.11 Six Non-Executive Members

3.11.1 The ICB will appoint six Non-Executive Members.

3.11.2 These members will be approved and appointed by the Chair.

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

c) 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 Committee.

3.11.4 Individuals will not be eligible if:

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

3.11.5 The term of office for a Non-Executive Member will be three years and the total number of terms an individual may serve is three terms or nine years, whichever is lesser.

3.11.6 Initial appointments may be for a shorter period, in order to avoid all Non-Executive Members retiring at once.

3.11.7 Subject to satisfactory appraisal the Chair may approve the reappointment of a Non-Executive Member up to the maximum number of terms permitted for their role.

3.12 Board Members: Removal from Office

3.12.1 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.

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

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance;

b) If they fail to attend a minimum of 75% of the meetings to which they are invited 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 dishonesty, misrepresentation (either knowingly or fraudulently), defamation of any member of the ICBS (being slander or libel), abuse of position, non-declaration of a known conflict of interest, seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise;
e) Are deemed to have failed to uphold the Nolan Principles; and
f) Are subject to disciplinary proceedings by a regulator or professional body.

3.12.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.12.2 apply.

3.12.4 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.

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

3.12.6 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.

3.13 Terms of Appointment of Board Members

3.13.1 With the exception of the Chair and Non-Executive Members, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee, in line with the ICB remuneration policy and any other relevant policies published in the Governance Handbook and any guidance issued by NHS England or other relevant body. Remuneration for the Chairs will be set by NHS England. Remuneration for Non-Executive Members will be set by a local group comprising of the Chair, Chief Executive, Chief People Officer, and a Partner Member.

3.13.2 Other terms of appointment for Board Members will be determined by the Remuneration Committee.

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

3.14 Specific arrangements for appointment of Ordinary Members made at establishment

3.14.1 Individuals may be identified as “designate ordinary members” prior to the ICB being established.

3.14.2 Relevant nomination procedures for partner members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the provisions of 3.5 to 3.7.

3.14.3 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 to 3.12 of this Constitution. However, a modified process, agreed by the Chair, will be considered valid.

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

3.14.5 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.

4 Arrangements for the Exercise of our Functions.

4.1 Good Governance

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

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

4.2 General

4.2.1 The ICB will:

a) comply with all relevant laws, including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;
b) comply with directions issued by the Secretary of State for Health and Social Care;
c) comply with directions issued by NHS England;

d) have regard to statutory guidance, including that issued by NHS England;
e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England; and
f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with a)–f) above, documenting them as necessary in this Constitution, its Governance Handbook, and other relevant policies and procedures as appropriate.

4.3 Authority to Act

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

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

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

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

4.4 Scheme of Reservation and Delegation

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

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

4.4.3 The SoRD sets out:

a) those functions that are reserved to the board;
b) those functions that have been delegated to an individual or to committees and sub committees;
c) those functions delegated to another body, or to be exercised jointly with another body, under sections 65Z5, 65Z6 or 75 of the 2006 Act.

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

4.5 Functions and Decision Map

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

4.5.2 The Functions and Decision Map is published in the Governance Handbook and on the ICB website which can be found at http://www.nhsdorset.nhs.uk/

4.5.3 The map includes:

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

4.6 Committees and Sub-Committees

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

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

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

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and sub-committees and, therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB, will be required to comply with reporting and assurance arrangements set out in their terms of reference.

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

4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be appointed by the Chair. The Chair will not appoint an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

4.6.7 All members of committees and sub-committees are required to act in accordance with this Constitution, including the Standing Orders, as well as the SFIs and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

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

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

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

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

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

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

4.7 Delegations made under section 65Z5 of the 2006 Act

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

4.7.2 All delegations made under these arrangements are set out in the SoRD and 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 the 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:

a) conducting the business of the ICB;

b) the procedures to be followed during meetings; and

c) The process to delegate functions.

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

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

5.2 Standing Financial Instructions (SFIs)

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

5.2.2 A copy of the SFIs published in the Governance Handbook.

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

6.1 Conflicts of Interest

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

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published in the Governance Handbook.

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 Standards of Business Conduct Policy.

6.1.6 The ICB will appoint one of its Non-Executive Members to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;
b) be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
c) support the rigorous application of conflict of interest principles and policies;
d) provide independent advice and judgement to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
e) provide advice on minimising the risks of conflicts of interest.

6.2 Principles

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

a) Decision-making must be geared towards meeting the statutory duties of ICBs at all times, including the triple aim. Any individual involved in decisions relating to ICB functions must be acting clearly in the interests of the ICB and of the public, rather than furthering direct or indirect financial, personal, professional or organisational interests.

b) ICBs have been created to give statutory NHS providers, local authority and primary medical services (general practice) nominees a role in decision-making. These individuals will be expected to act in accordance with the first principle, and whilst it should not be automatically assumed that they are personally or professionally conflicted just by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations, the possibility of actual and perceived conflicts of interests arising will remain. For all decisions, ICBs will need to carefully consider whether an individual's role in another organisation could result in actual or perceived conflicts of interest and whether or not that outweighs the value of the knowledge they bring to the process.

c) The personal and professional interests of all ICB board members, ICB committee members and ICB staff who are involved in decision taking need to be declared, recorded and managed appropriately. Declarations must be made as soon as practicable after the person becomes aware of the conflict or potential conflict and, in any event, within 28 days of the person becoming aware. This is already standard practice in existing NHS organisations such as CCGs. This includes being clear and specific about the nature of any interest, and about the nature of any conflict that may arise regarding a particular decision.

d) If an interest is declared but there is no risk of a conflict arising then no further action need be taken (although this will still need to be recorded). However, if a material interest is declared, then it should be considered to what extent this material interest affects the balance of the discussion and decision-making process. In doing so the ICB should ensure conflicts of interest (and potential conflicts of interest) do not, (and do not appear), to affect the integrity of the ICB's decision making processes.

e) ICBs should consider the composition of decision-making forums and should clearly distinguish between those individuals who should be involved in formal decision taking, and those whose input informs decisions. In particular ICBs should consider the perspective the individual brings and the value they

add to both discussions around particular decisions and in actually taking part in the decision including the ability to shape the ICB's understanding of how best to meet patients' needs and deliver care for their populations. The way Conflicts of Interest are managed should reflect this distinction. For example, where independent providers (including the VCSE sector) hold contracts for services it would be appropriate and reasonable for the body to involve them in discussions, for example about pathway design and service delivery, particularly at place-level. However, this would be clearly distinct from any considerations around contracting and commissioning, from which they would be excluded.

f) Actions to mitigate conflicts of interest should be proportionate and should seek to preserve the spirit of collective decision-making wherever possible. Mitigation should take account of a range of factors including the perception of any conflicts and how a decision may be received if an individual with a perceived conflict is involved in that decision, and the risks and benefits of having a particular individual involved in making the decision.

g) The way conflicts of interest are declared and managed should contribute to a culture of transparency about how decisions are made. In particular when adopting a specific approach to mitigate any conflicts of interest (including perceived conflicts) ICBs should ensure that the reason for the chosen action is documented in minutes or records.

h) These factors should be read in conjunction with other relevant NHSE/I statutory guidance, including guidance on the provider selection regime and guidance on joint working and delegation arrangements. In relation to the provider selection regime, as is already established practice in the NHS, where decisions are being taken as part of a formal competitive procurement of services, any individual who is associated with an organisation that has a vested interest in the procurement should recuse themselves from the process.

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 which can be found at http://www.nhsdorset.nhs.uk/.

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

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

6.4 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 that policy relating to the management of conflicts of interest.

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

7 Arrangements for ensuring Accountability and Transparency

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

7.2 Principles

7.2.1 The ICB will demonstrate its accountability and transparency and meet its statutory requirements to:

a) Publish our Constitution and other key documents including the Governance Handbook;
b) Appoint non-executive members to the Board;

c) Manage actual or potential conflicts of interest in line with the NHS England's Conflicts of Interests Statutory Guidance and expected standards of good practice;
d) Hold ICB meetings in public (except where we believe that it would not be in the public interest);
e) Publish an annual commissioning strategy that takes account of the priorities in the health and wellbeing strategy, as well as other relevant policy objectives;
f) Procure services in accordance with prevailing legislation and guidance and publish a Procurement Strategy;
g) Involve the public, in accordance with the ICB duties under section 14Z44 of the 2006 Act, and as set out in more detail in the ICB policies and procedures, including those in the Governance Handbook;
h) When discharging its duties under section 14Z44, the ICB will ensure that it follows the key principles of openness, early and active involvement and fairness;
i) Comply with local authority health overview and scrutiny requirements;
j) Meet annually in public to present an annual report which is then published;
k) Produce annual accounts which are externally audited;
l) Publish a clear complaints process;
m) Comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB;
n) Provide information to NHS England as required; and
o) Be an active member of the local Health and Wellbeing Boards.

7.3 Meetings and publications

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

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

7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

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

7.3.6 Information will be provided to NHS England as required.

7.3.7 The constitution and Governance Handbook will be published as well as other key documents, including but not limited to:

a) Conflicts of interest policy and procedures
b) Registers of interests.

7.3.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years (the "Joint Forward Plan"). The plan will, in particular:

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

b) Explain how the ICB proposes to discharge its duties under:

- sections 14Z34 to 14Z45 (general duties of integrated care boards) and
- sections 223GB and 223N (financial duties).

c) set out any steps that the ICB proposes to take to implement the two joint local health and wellbeing strategies prepared by the Health and Wellbeing Boards on behalf of the ICB and two of the partner local authorities listed at 3.7.1.

d) set out any steps that the integrated care board proposes to take to address the particular needs of children under the age of 25.

e) set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

7.4 Scrutiny and Decision Making

7.4.1 At least three Non-Executive Members will be appointed to the Board, including the Chair; and all of the board and committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

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

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

a) Complying with existing procurement rules until the NHS Provider Selection Regime comes into effect.

b) evidencing that it has properly exercised the responsibilities conferred on it by the regime by:

- publishing the intended selection approach in advance, where appropriate.
- 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.

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

7.5 Annual Report

7.5.1 The ICB will publish an annual report, in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report, must in particular:

a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards);
b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan);
c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised); and
d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

8 Arrangements for Determining the Terms and Conditions of Employees.

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

8.1.2 The board has established a Remuneration Committee, which is chaired by an Non-Executive Member other than the Chair or Audit Chair.

8.1.3 The membership of the Remuneration Committee is determined by the board. No employees may be a member of the Remuneration Committee, but the board ensures that the Remuneration Committee has access to appropriate HR advice authorising it to obtain legal and/or other independent professional advice and to secure the attendance of anyone with relevant experience and expertise, if it considers this necessary.

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

8.1.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published in the Governance Handbook.

8.1.6 The duties of the Remuneration Committee include:

a) Setting the ICB pay policy and standard terms and conditions;
b) Making arrangements to pay employees such remuneration and allowances as it may determine;
c) Set remuneration and allowances for members of the board in accordance with paragraph 3.14.1; and
d) Any other relevant duties set out within its terms of reference.

8.1.7 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

9.1.1 In line with section 14Z45(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

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

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

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

a) Put the voices of people and communities at the centre of decision making and governance, at every level of the ICS;
b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions;
c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect ;
d) Build relationships with excluded groups – especially those affected by inequalities;
e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners;
f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust;
g) Use community development approaches that empower people and communities, making connections to social action;
h) Use co-production, insight and engagement to achieve accountable health and care services;
i) Co-produce and redesign services and tackle system priorities in partnership with people and communities; and
j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

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

9.1.5 These arrangements, include:

a) Using public engagement and insight to inform decision-making
b) Redesigning models of care and tackling system priorities in partnership with staff, people who use care and support and their carers and representatives (if any)
c) Working with Healthwatch and the voluntary, community and social enterprise sector as key transformation partners
d) Understanding the community's experience and aspirations for health and care
e) Reaching out to excluded groups, especially those affected by inequalities
f) Providing clear and accessible public information about vision, plans and progress to build understanding and trust
g) Using community development approaches that empower people and communities, making connections to social action.

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.
Board	The Board of the ICB.
Area	The geographical area that the ICB has responsibility for is the District of Bournemouth, Christchurch and Pool and District of Dorset.
Chief Finance Officer	An individual who is appointed to the ICB and who will fulfil the NHSE policy requirement to appoint a Director of Finance.
Chief Medical Officer	An individual who is appointed to the ICB and who will fulfil the NHSE policy requirement to appoint a Medical Director.
Chief Nursing Officer	An individual who is appointed to the ICB and who will fulfil the NHSE policy requirement to appoint a Nursing Officer.
Committee	A committee created and appointed by the ICB board.
Executive Director	The following Board Members: • Chief Executive • Chief Finance Officer • Chief Medical Officer • Chief Nursing Officer
Forward plan condition	To enable relevant CCG(s) and designate ICB leaders to identify the relevant partner trusts, guided by whether they are essential to development and delivery of the joint forward plan, and allowing for local discretion.
The Governance Handbook	The ICB's Governance Handbook maintained and published by the ICB. The Governance Handbook includes key corporate governance documents.
Health and Wellbeing Boards	The committees of the two local authorities listed in paragraph **Error! Reference source not found.** which are established under section 194 of the Health and Social Care Act 2012.

Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
ICB Board	Members of the ICB.
Integrated Care Partnership	The joint committee for the 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. Those local authorities are listed at clause 1.3.1. The Integrated Care Partnership's functions include a duty to prepare an "integrated care strategy" in accordance with section 116ZA of the Local Government and Public Involvement in Health Act 2007 as amended by the Health and Care Act 2022.
Joint Forward Plan	The system plan prepared before the start of each financial year by the ICB and its partner NHS trusts and NHS foundation trusts, in accordance with section 14Z52 of the 2006 Act.
Level of services provided condition	To ensure that all trusts are partners to at least one ICB, even if they do not meet the forward plan condition for any future ICB. For example, this could apply to some specialist trusts.
Nolan Principles	The Seven Principles of Public Life, which are: selflessness, integrity, objectivity, accountability, openness, honesty, and leadership.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description • the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.

Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Sub-Committee	A committee created and appointed by and reporting to a committee.

Appendix 2 Standing Orders

1 Introduction

1.1 These Standing Orders have been drawn up to regulate the proceedings of NHS Dorset 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 1 July 2022.

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

2.3 Amendments to these Standing Orders will be made as per 1.5.2 of the Constitution.

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

3 Interpretation, application and compliance

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

3.2 These Standing Orders apply to all meetings of the board, including its committees and sub-committees unless otherwise stated. All references to board are inclusive of committees and sub-committees unless otherwise stated.

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

3.4 In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the Corporate Office Manager will provide a settled view which shall be final.

3.5 All members of the board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible. Where any non-compliance relates to the Chief Executive Officer, it should be disclosed to the Chair.

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

formal meeting of the board for action or ratification and the Audit 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.
d) A failure to give notice in accordance with the above requirements shall not invalidate a decision otherwise taken in accordance with these Standing Orders.

4.1.3 A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting. Where a meeting is called on an urgent basis, in accordance with 4.1.2(c) above, a public notice shall be posted at the time that the meeting is called.

4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting.

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 Members present shall agree who will preside over the meeting in the Chair's absence.

4.2.3 The board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and

sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

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

4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted to the Secretariat at least seven working 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 http://www.nhsdorset.nhs.uk/.

4.4 Nominated Deputies

4.4.1 With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the board may nominate a suitably qualified, informed and empowered deputy to attend a meeting of the board that they are unable to attend. This must be approved by the Chair prior to the meeting in question. The deputy may speak and vote on their behalf.

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

4.5 Virtual attendance at meetings

4.5.1 The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means, unless the terms of reference for any committee or sub-committee prohibit this.

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

4.6 Quorum

4.6.1 The quorum for meetings of the board will be a third of the members, including:

a) one Executive Member;
b) one Partner Member; and
c) one Non-Executive Member.

To ensure quoracy, one member must hold a current clinical registration.

4.6.2 For the sake of clarity:

a) Members in this context means posts that are filled.
b) No person can act in more than one capacity when determining the quorum.
c) 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.
d) A nominated deputy permitted in accordance with Standing Order 4.5 will count towards quorum for meetings of the Board.

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

4.7 Vacancies and defects in appointment

4.7.1 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 members.

4.7.2 In the event of any vacancies or defect in appointment of board members, Standing Order 4.9.1 shall continue to apply.

4.8 Decision making

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

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

a) All members of the board who are present at the meeting will be eligible to cast one vote each.
b) An absent member may 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. Proxies may only validly be appointed by a notice in writing which:

(i) states the name and address of the Member appointing the proxy;

(ii) identifies the person appointed to be that Member's proxy and the decision in relation to which that person is appointed;

(iii) is signed by or on behalf of the Member appointing the proxy, or is authenticated by the relevant Member; and

(iv) is delivered to the Chair in accordance with this Constitution and any instructions contained in the notice of the decision to which they relate.

c) For the sake of clarity, any Participants (as detailed within paragraph 2.3 of the constitution) will not have voting rights.

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

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

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

Disputes

4.8.3 Where necessary boards may draw on third-party support such as peer review or mediation by NHS England and NHS Improvement.

Urgent decisions

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

4.8.5 The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair and Chief Executive subject to every effort having been made to consult with two Non-Executive Members or Partner members.

4.8.6 The exercise of such powers shall be reported to the next formal meeting of the Board for noting and to the Audit Committee for oversight.

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

4.9 Minutes

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

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

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

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

4.10 Admission of public and the press

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

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

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

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

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

5 Suspension of Standing Orders

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

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

5.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit 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. Any two of the following individuals or officers are authorised to authenticate its use by their signature:

a) The Chief Executive Officer;
b) The Chair;
c) The Chief Finance Officer;
d) Other duly authorised executive directors.