NHS
Central East
Integrated Care Board

Central East
Integrated Care Board

CONSTITUTION

Document Control Sheet

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Table of Contents

1.0 Introduction 5

1.1 Background / foreword 5

1.2 Name 5

1.3 Area covered by the Integrated Care Board 5

1.4 Statutory framework 6

1.5 Status of this Constitution 7

1.6 Variation of this Constitution 7

1.7 Related Documents 8

2.0 Composition of the Board of the Integrated Care Board 9

2.1 Background 9

2.2 Board membership 10

2.3 Regular participants and observers at Board meetings 11

3.0 Appointments process for the Board 12

3.1 Eligibility criteria for Board membership 12

3.2 Disqualification criteria for Board membership 12

3.3 Chair 14

3.4 Deputy Chair and Senior Non-executive member 14

3.5 Chief Executive 15

3.6 Partner Members – NHS trusts and foundation trusts (or their successor bodies) 15

3.7 Partner Members – providers of primary medical services 17

3.8 Partner Members – local authorities 18

3.9 Medical Director (known as the Executive Clinical Director of Utilisation Management) 20

3.10 Director of Nursing (known as the Executive Clinical Director of Total Quality Management) 20

3.11 Director of Finance (known as the Executive Director of Finance, Resources & Contracts) 20

3.12 Non-executive Members 21

3.13 Other Board members 22

3.14 Board members: Removal from Office 23

3.15 Terms of appointment of Board members 24

4.0 Arrangements for the exercise of our functions 24

4.1 Good governance 24

4.2 General 25

4.3 Authority to act 25

4.4 Scheme of Reservation and Delegation 26

4.5 Functions and Decision Map 26

4.6 Committees and sub-committees 26

4.7 Delegations made under section 65Z5 of the 2006 Act 28

5.0 Procedures for making decisions 28

5.1 Standing Orders 28

5.2 Standing Financial Instructions 29

6.0 Arrangements for conflict of interest management and standards of business conduct 29

6.1 Conflicts of Interest 29

6.2 Principles 30

6.3 Declaring and registering interests 30

6.4 Standards of business conduct 31

7.0 Arrangements for ensuring accountability and transparency 31

7.2 Principles 32

7.3 Meetings and publications 32

7.4 Scrutiny and decision making 33

7.5 Annual report 33

8.0 Arrangements for determining the terms and conditions of employees 34

9.0 Arrangements for public involvement 35

Appendix 1: Definitions of Terms Used in This Constitution 37

Appendix 2: Standing Orders 40

1.0 Introduction 40

2.0 Amendment and review 40

3.0 Interpretation, application and compliance 40

4.0 Meetings of the Integrated Care Board 41

4.1 Calling Board Meetings 41

4.2 Chair of a meeting 41

4.3 Agenda, supporting papers and business to be transacted 42

4.4 Petitions 42

4.5 Nominated Deputies 42

4.6 Virtual attendance at meetings 42

4.7 Quorum 42

4.8 Vacancies and defects in appointments 43

4.9 Decision making 43

4.10 Minutes 44

4.11 Admission of public and the press 44

5.0 Suspension of Standing Orders 45

6.0 Use of Seal and authorisation of documents. 45

1.0 Introduction

1.1 Background / foreword

1.1.1 NHS England has set out the following as the four core purposes of integrated care systems (ICSs):

a) Improve outcomes in population health and healthcare.
b) Tackle inequalities in outcomes, experience and access.
c) Enhance productivity and value for money.
d) Help the NHS support broader social and economic development.

1.1.2 The system is made up of two components: an Integrated Care Board and an Integrated Care Partnership. The Integrated Care Board has the function of arranging the provision of those services in accordance with the Health and Care Act 2021. Together with each responsible local authority whose area coincides with, or falls wholly or partly within the Board's area, they must establish a joint committee known as an Integrated Care Partnership (ICP). The ICP must prepare a strategy setting out how the assessed needs in relation to its area are to be met.

1.1.3 This Constitution relates to the Integrated Care Board.

1.1.4 The Integrated Care Board 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 Central East Integrated Care Board ("the ICB").

1.3 Area covered by the Integrated Care Board

1.3.1 The area covered by the ICB includes all of the Borough of Bedford, District of Central Bedfordshire, Borough of Luton, City of Milton Keynes, City of Cambridge, District of East Cambridgeshire, District of Fenland, District of Huntingdonshire, City of Peterborough, District of South Cambridgeshire, Borough of Broxbourne, Borough of Dacorum, District of East Hertfordshire, , Borough of Hertsmere, District of North Hertfordshire, City of St Albans, Borough of Stevenage, District of Three Rivers, District of Uttlesford, Borough

of Watford, the Borough of Welwyn Hatfield and also part of the County of Buckinghamshire.

1.3.2 Where the area of the ICB is not fully co-terminus with a local government area it is necessary to define this using Lower-layer Super Output Areas (LSOAs). The list of LSOAs in the County of Buckinghamshire, which are covered by the ICB are listed below:

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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 http://www.centraleast.icb.nhs.uk

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

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act).
b) Exercising its functions effectively, efficiently and economically (Section 14Z33 of the 2006 Act).

c) Duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014).
d) Adult safeguarding and carers (the Care Act 2014).
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35); and
f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000).
g) Provisions of the Civil Contingencies Act 2004.

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

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

a) Section 14Z34 (improvement in quality of services).
b) Section 14Z35 (reducing inequalities).
c) Section 14Z38 (obtaining appropriate advice).
d) Section 14Z40 (duty in respect of research).
e) Section 14Z43 (duty to have regard to effect of decisions).
f) Section 14Z45 (public involvement and consultation).
g) Sections 223GB to 223N (financial duties), and
h) Section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

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

1.5 Status of this Constitution

1.5.1 The ICB was established on 1 April 2026 by The Integrated Care Boards (Establishment and Abolition) Order 2026, which made provision for its Constitution by reference to this document.

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

1.6 Variation of this Constitution

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

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

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

a) The Chief Executive may periodically propose amendments to the Constitution, which shall be considered and must be approved by the Board of the ICB before submission to NHS England.
b) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

1.7.1 This Constitution is also supported by several 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 –** 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, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS Trust, NHS Foundation Trust, local authority, combined authority or any other prescribed body: or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority, or any other prescribed body; or to a joint committee of the ICB and one 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 3.7.2.

e) **Key policy documents –** which should also be included in the Governance Handbook or linked to it including:

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

2.0 Composition of the Board of the Integrated Care Board

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.centraleast.icb.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 NHS England Policy requires the ICB to appoint the following additional ordinary members:

a) Three executive members, namely:

- Medical Director (known as the Executive Clinical Director of Utilisation Management).
- Director of Nursing (known as the Executive Clinical Director of Total Quality Management).
- Director of Finance (known as the Executive Director of Finance, Resources & Contracts)

b) At least two Non-executive Members.

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

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

While the Partner Member 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 or their own organisation.

2.2 Board membership

2.2.1 The ICB has nine Partner Members:

a) Three Partner Members NHS and foundation trusts.
b) Three Partner Members primary medical services.
c) Three Partner Members local authorities.

2.2.2 The ICB has also appointed the following further ordinary members to the Board:

a) Three further Non-executive Members.
b) Three further Executive Directors
c) One Board Member – Voluntary, Community Faith and Social Enterprise Sector

2.2.3 The Board is therefore composed of the following 23 members:

a) Chair.
b) Chief Executive.
c) Three Partner Members NHS and foundation trusts.
d) Three Partner Members primary medical services.
e) Three Partner Members local authorities.
f) Five Non-executive Members (one of which, but not the Audit and Risk Committee Chair, will be appointed Deputy Chair; and one of which, who may be the Deputy Chair or the Audit and Risk Committee Chair, will be appointed the Senior non-executive member).
g) Director of Finance (known as the Executive Director of Finance, Resources & Contracts)
h) Medical Director (known as the Executive Clinical Director of Utilisation Management)
i) Director of Nursing (known as the Executive Clinical Director of Total Quality Management)
j) Executive Director Neighbourhood Health Places & Partnerships
k) Executive Director Strategy, Planning & Commissioning
l) Executive Director Corporate Services & ICB Development
m) Board Member – Voluntary, Community Faith and Social Enterprise Sector

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 Regular participants and observers at Board meetings

2.3.1 The Board may invite specified individuals to be participants or observers at its meetings to inform its decision-making and the discharge of its functions as it sees fit.

2.3.2 Participants will receive advanced copies of the notice, agenda, and papers for Board meetings. They may be invited to attend any or all 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.

a) One Director of Public Health.
b) One Healthwatch Representative.

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

2.3.4 Participants and / or observers may be asked to leave the meeting by the Chair in the event that the Board passes a resolution to exclude the public as per the standing orders.

3.0 Appointments process for the Board

3.1 Eligibility criteria for Board membership

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test".
b) Be committed to upholding the Seven Principles of Public Life (known as the Nolan Principles).
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.
d) All individuals appointed to roles on the Board are responsible for familiarising themselves with the eligibility and ineligibility requirements, confirming their eligibility prior to appointment and immediately notifying the Chair of the ICB of a change of circumstances that may render them no longer eligible.

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 outcome of the proceedings was a sentence of

imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who, has been dismissed within the period of five years immediately preceding the date of the proposed appointment, other than because of redundancy, from paid employment by any health service body.

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

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

3.2.7 A health care professional, meaning an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002, or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licences the profession concerned ("the regulatory body"), in connection with the person's fitness to practice 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 practicing the profession in question, where that decision has not been superseded, or
d) A decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

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

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

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

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

3.3 Chair

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

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

a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

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

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

3.4 Deputy Chair and Senior Non-executive member

3.4.1 The Deputy Chair is to be appointed from amongst the Non-executive Members by the board subject to the approval of the Chair.

3.4.2 No individual shall hold the position of Chair of the Audit and Risk Committee and Deputy Chair at the same time.

3.4.3 The Senior Non-executive Member is to be appointed from amongst the non-executive members by the board subject to the approval of the Chair.

3.5 Chief Executive

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

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

3.5.3 The Chief Executive must fulfil the following additional eligibility criteria:

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

3.5.4 Individuals will not be eligible if:

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

b) subject to clause 3.5.3(a), they hold any other employment or executive role other than chief executive of another Integrated Care Board.

3.6 Partner Members – NHS trusts and foundation trusts (or their successor bodies)

3.6.1 These Partner Members are jointly nominated by the NHS trusts and / or foundation trusts that 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) Bedfordshire Hospitals NHS Foundation Trust.
b) Cambridgeshire Community Services NHS Trust.
c) Central and North West London NHS Foundation Trust.
d) East London NHS Foundation Trust.
e) East of England Ambulance Service NHS Trust.
f) Milton Keynes University Hospital NHS Foundation Trust.
g) South Central Ambulance Service NHS Foundation Trust.
h) Cambridgeshire and Peterborough NHS Foundation Trust
i) Cambridge University Hospitals NHS Foundation Trust
j) North West Anglia NHS Foundation Trust
k) Royal Papworth Hospital NHS Foundation Trust

l) East and North Hertfordshire NHS Trust
m) West Hertfordshire Teaching Hospitals NHS Trust
n) Hertfordshire Community NHS Trust
o) Hertfordshire Partnership University NHS Foundation Trust
p) Central London Community Healthcare NHS Trust

3.6.2 The partner member must fulfil the eligibility criteria set out at 3.1 and the following additional eligibility criteria:

a) Be a Chief Executive Officer or Executive Director of one of the NHS trusts or foundation trusts delivering services within the ICB's area.
b) Provide the Board with knowledge and experience of the NHS acute or community and mental health sectors.

3.6.3 Individuals will not be eligible if:

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

3.6.4 The member will be appointed by an appointments panel subject to the approval of the Chair.

3.6.5 The appointment process will be as follows:

a) Joint nomination:
- When a vacancy arises, each eligible organisation listed at 3.6.1 will be invited to make up to one nomination per role.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within five working days being deemed to constitute agreement.
- This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the reason for objection is to be formally documented and provided to the Chair, and the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)
- The full list of nominees will be considered by a panel convened by the Chief Executive or their nominated deputy.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is

initiated) and will confirm that nominees meet the requirements set out in clause 3.6.2 and 3.6.3.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.6.6 The term of office for this partner member will be three years and the total number of terms they may serve is two. One term may be extended up to one year subject to approval by the Chair.

3.7 Partner Members – providers of primary medical services

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

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

3.7.3 The partner member must fulfil the eligibility criteria set out at 3.1 and the following additional eligibility criteria:

a) Work in the ICB area for a minimum of two sessions per week.
b) Be a health care professional with primary care leadership experience, who is either actively working within a provider of primary medical services or Community Pharmaceutical Services or Primary Dental Services or Primary Ophthalmic Services – operating from a main base within the geographical areas covered by the ICB, or who has done so in the ICB catchment area within a reasonable period, to ensure they are able to provide a current perspective of their sector.
c) The post holder(s) will meet any other criteria set out in NHS England guidance or supporting legislation; and
d) As a member of the Board – consider the effect of their recommendations or proposals on the better health and wellbeing of everyone, the quality of care for all patients, and the sustainable use of NHS resources (referred to as the "Triple Aim")

3.7.4 Individuals will not be eligible if:

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

3.7.5 The Member will be appointed by the Appointments Panel subject to the approval of the Chair.

3.7.6 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed in the appendix in the Governance Handbook will be invited to make up to one nomination per role.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within five working days being deemed to constitute agreement.
- This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the reason for objection is to be formally documented and provided to the Chair, and the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)
- The full list of nominees will be considered by a panel convened by the Chief Executive or their nominated deputy.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.2 and 3.7.3.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.7.7 The term of office for this partner member will be three years and the total number of terms they may serve is two. One term may be extended up to one year subject to approval by the Chair.

3.8 Partner Members – local authorities

3.8.1 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) Bedford Borough Council.

b) Buckinghamshire Council.
c) Central Bedfordshire Council.
d) Luton Borough Council.
e) Milton Keynes Council.
f) Cambridgeshire County Council
g) Peterborough City Council
h) Hertfordshire County Council

3.8.2 The partner member will fulfil the eligibility criteria set out at 3.1 and the following additional eligibility criteria:

a) Be the Chief Executive or hold a relevant executive level role of one of the bodies listed at 3.8.1.

3.8.3 Individuals will not be eligible if:

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

3.8.4 The member will be appointed by an appointments panel subject to the approval of the Chair.

3.8.5 The appointment process will be as follows:

a) Joint nomination:
- When a vacancy arises, each eligible organisation listed at 3.8.1 will be invited to make up to one nomination per role.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
  All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within five working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the reason for objection is to be formally documented and provided to the Chair, and the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)
- The full list of nominees will be considered by a panel convened by the Chief Executive or their nominated deputy.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.8.2 and 3.8.3.

- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval
   - The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.8.6 The term of office for this partner member will be three years and the total number of terms they may serve is two. One term may be extended up to one year subject to approval by the Chair.

3.9 Medical Director (known as the Executive Clinical Director of Utilisation Management)

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

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

3.9.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply.

3.9.3 This member will be appointed by an appointments panel subject to the approval of the Chair.

3.10 Director of Nursing (known as the Executive Clinical Director of Total Quality Management)

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

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

3.10.2 Individuals will not be eligible if:

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

3.10.3 This member will be appointed by an appointments panel subject to the approval of the Chair.

3.11 Director of Finance (known as the Executive Director of Finance, Resources & Contracts)

3.11.1 This member will fulfil the eligibility criteria set out at 3.1 and 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.

3.11.2 Individuals will not be eligible if:

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

3.11.3 This member will be appointed by an appointments panel subject to the approval of the Chair.

3.12 Non-executive Members

3.12.1 The ICB will appoint five Non-executive Members.

3.12.2 These members will be appointed by an appointments panel subject to the approval of the Chair.

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

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

3.12.4 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.

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

3.12.6 Initial appointments may be for a shorter period 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.

3.12.7 Subject to satisfactory annual appraisal, the Chair may approve the re-appointment of a Non-executive Member up to the maximum number of terms permitted for their role.

3.13 Other Board members

3.13.1 **Board Member –** Voluntary Community Faith Social Enterprise Sector (VCFSE)

a) This member is nominated by the Bedfordshire, Luton and Milton Keynes VCSE Steering Group, Cambridgeshire and Peterborough Voluntary Services Network and Hertfordshire & West Essex VCFSE Alliance.

b) This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
- Be the Chief Executive, Chair or hold a relevant Executive level role in one of the VCFSE sector legal organisations; and
- Any criteria set out in NHS England's guidance from time to time.

c) Individuals will not be eligible if
- Any of the disqualification criteria set out in 3.2 apply; and
- any criteria as set out in NHS England guidance applies

d) This member will be appointed by a panel subject to the approval of the Chair.

e) The appointment process will be as follows:
- When a vacancy arises, each VCFSE body listed in 3.13.1.(a) will be invited to make up to one nomination.
- The nomination of an individual must be seconded by one other eligible member of the VCFSE body listed in 3.13.1.(a).
- Eligible members may nominate individuals from their own organisation or another organisation.
- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.13.2 a, b and c.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
- A fit and proper person test will also be undertaken on the preferred candidate before appointment.
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified

f) The term of office for the Board Member – Voluntary, Community, Faith and Social Enterprise Sector will normally be three years (but not less than two years) or end at such time as they cease to be eligible for appointment. The total number of years they may serve is six.

3.13.2 Three Executive Directors

3.13.2.1 The Chief Executive will appoint three Executive Directors.

a) Executive Director Neighbourhood Health Places & Partnerships
b) Executive Director Strategy, Planning & Evaluation
c) Executive Director Corporate Services & ICB Development

3.13.2.2.4 These members will fulfil the eligibility criteria set out at 3.1.

3.13.2.3.5 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; and
b) Any criteria as set out in NHS England guidance applies.

3.14 Board members: Removal from Office

3.14.1 Arrangements for the removal from office of Board members is subject to any terms set out in contracts for service or contracts of employment, and application of the relevant ICB policies and procedures.

3.14.2 Except for 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 not to 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 organisation into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; or non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise.
e) Are deemed to have failed to uphold the Nolan Principles of Public Life.
f) Are subject to disciplinary proceedings by a regulator or professional body.

3.14.3 Members may be suspended pending the outcome of an investigation including, for example, if they are suspended or under investigation by a regulator or professional body.

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

3.14.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State for Health and Social Care.

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

a) Terminate the appointment of the Chief Executive of the ICB; and
b) Direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.15 Terms of appointment of Board members

3.15.1 Except for the Chair and Non-executive Members, arrangements for remuneration and any allowances will be agreed by the Remuneration and Workforce Committee in line with the ICB Remuneration Policy and any other relevant policies published at http://www.centraleast.icb.nhs.uk and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for non-executive members will be set by a separate panel, the details of which are set out in the Governance Handbook.

3.15.2 Other terms of appointment will be determined by the Remuneration and Workforce Committee.

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

4.0 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 Standards of Business Conduct and behaviours is published http://www.centraleast.icb.nhs.uk

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.

4.1.4 Individual evaluation will demonstrate whether each director continues to contribute effectively.

4.1.5 All Board members will have access to the advice of the ICB's governance lead, who is responsible for advising the Board on all governance matters.

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.
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.

4.3.4 Where arrangements are made under Section 65Z5 or Section 75 of the 2006 Act the Board must authorise the arrangement, which must be described as appropriate in the Scheme of Reservation and Delegation.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a Scheme of Reservation and Delegation (SoRD) which is published in full here: http://www.centraleast.icb.nhs.uk

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

4.4.3 The SoRD sets out:

a) Those functions that are reserved to the Board.
b) Those functions that have been delegated to an individual or to committees and sub-committees.
c) Those functions delegated to another Body or to be exercised jointly with another body, under Section 65Z5 and 65Z6 of the 2006 Act.

4.4.4 The ICB remains accountable for all 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 within the Governance Handbook and can be found http://www.centraleast.icb.nhs.uk here:

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 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 relating to committees and sub-committees established by the Board 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 the terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB, will be required to:

a) Provide a written report to every Board meeting where appropriate. At each meeting of the Board, the chair of the committee will present a short report in writing which highlights key matters.
b) A committee chair may also request an executive lead attend the Audit and Risk Committee to discuss significant risks or matters of issue arising from internal or external audit reports in greater detail.

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

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

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

4.6.8 The following Committees will be maintained:

a) **Audit and Risk Committee:** This committee is accountable to the Board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit. The Audit and Risk Committee will be chaired by a Non-executive Member (other than the Chair and Deputy Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration and Workforce 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 Workforce Committee will be chaired by a Non-executive Member other than the Chair or the Chair of Audit and Risk Committee.

4.6.9 The terms of reference for each of the above committees are published in the 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 Governance Handbook and further information about these committees, including terms of reference, are also 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.

5.0 Procedures for making decisions

5.1 Standing Orders

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

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

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

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

5.2 Standing Financial Instructions

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

5.2.2 A copy of the SFIs is published within the Governance Handbook and can be found here: http://www.centraleast.icb.nhs.uk

6.0 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 on the website here: http://www.centraleast.icb.nhs.uk

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

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

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

6.1.6 The ICB has appointed the Audit and Risk Committee 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 ICB 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) All applicants for any position within the ICB (as either a worker under a contract for service arrangement or an employee) will be required as part of the recruitment process to declare any relevant interests.
b) When an individual changes role or responsibility within the ICB, any change to the individual's interests should be declared immediately or within 28 days at the latest, indicating the date the change took effect.
c) Whenever an individual's circumstances change in a way that affects the ICB or they establish a new business or relationship, a further declaration may need to be made to reflect their change in circumstances. This could involve a conflict of interest ceasing to exist or a new one materialising.
d) All individuals are required to declare their interests in relation to any items on meeting Agendas. For meetings of the Board or its committees individuals are required to declare those interests in advance.

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 and workers.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB website here: http://www.centraleast.icb.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.

6.3.7 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's arrangements for Conflict of Interest Management and Standards of Business Conduct Policy.

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 arrangements for Conflict of Interest Management and Standards of Business Conduct Policy.

7.0 Arrangements for ensuring accountability and transparency

7.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Principles

7.2.1 The ICB will have regard to and demonstrate the competencies outlined in the values of the NHS Constitution.

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's 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:

- Conflicts of Interest Policy and procedures.
- Registers of interests.
- Key policies.

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

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

b) explain how the ICB proposes to discharge its duties under 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 Central East joint local health and care strategy

d) set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25

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

7.4 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 Seven Principles of Public Life (the Nolan Principles) 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) Establishing and using the appropriate decision-making arrangements to ensure procurements are robust and comprehensive, whilst maintaining proportionality.
b) Applying the required criteria in evaluation and decision-making regarding provision of clinical services to ensure services procured demonstrate the best combination of benefits to the population, patients and the taxpayer.
c) Establishing clear record-keeping protocols and ensuring appropriate transparency in decision-making to enable scrutiny of decisions.
d) Securing services in a way which reduces health inequalities and promotes social value.
e) Ensuring that procurement activities support service sustainability and are consistent with the integration and collaboration agenda of the ICB.
f) Undertaking procurement activities to ensure high levels of quality of care both for the present and into the future through the use of innovation.

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 that 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.

8.0 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 And Workforce Committee which is chaired by a Non-Executive member other than the Chair or Audit and Risk Committee Chair.

8.1.3 The membership of the Remuneration and Workforce Committee is determined by the Board. No employees may be a member of the Remuneration and Workforce Committee, but the Board ensures that the Remuneration and Workforce Committee has access to appropriate advice by:

a) The executive with responsibility for organisational development and workforce, and the governance lead attending as regular participants.

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

8.1.5 The main purpose of the Remuneration and Workforce 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 and Workforce Committee include:

a) Making decisions on behalf of the Board about remuneration, fees and allowances for employees of the ICB and people who provide services to the ICB. For the avoidance of doubt, this includes:
   - All employees regardless of the use or otherwise, of various pay frameworks, seniority or role.
   - People who fulfil clinical roles (such as clinical leads) who are neither employees nor on the Board.
   - The process or framework for agreeing rates for self-employed contractors.
   - All components of remuneration (including any performance-related elements and other benefits, such as lease cars).
   - Termination payments (including redundancy and severance payments) and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

b) Making decisions on behalf of the Board about allowances payable under pension schemes established by the ICB for its employees.

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

9.0 Arrangements for public involvement

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

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

9.1.2 In line with section 14Z54 of the 2006 Act, the ICB has made the following arrangements to consult its population on its system plan:

a) Ensure policies, programmes, service changes and more general communications and engagement campaigns will be discussed at a formative stage with partners, local people and communities.

b) Each partner organisation will ensure patients, citizens and local community voices, lived experiences and insights are sought, incorporated and where appropriate co-designed into policies, procedures and strategies of the Central East Integrated Care Board and wider Central East Integrated Care Partnership.
c) Working with Healthwatch and the voluntary, community, faith and social enterprise sector to ensure patient and public voice is embedded into the work of Central East Integrated Care Board, embracing co-production and co-design wherever possible.
d) To undertake a process of continuous involvement with local people and communities to ensure that insights and lived experiences inform decision making.
e) Each organisation complies with the legal framework, as set out for engagement with the health overview and scrutiny committees.
f) Clinicians are involved in communications and engagement to ensure that involvement is clinically led.
g) Other arrangements are set out in the People and Communities Engagement Strategy.

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 Integrated Care System.
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, faith 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 Integrated Care System – 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.

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
Area	The geographical area that the ICB has responsibility for, as defined in clause 1.3 of this Constitution.
Board level	An individual who has a designated / speciality role required at board level, who may not be a Board member. This may include Band 9 Directors under the NHS Agenda for Change pay Framework or Very Senior Managers.
Committee	A committee created and appointed by the Board of the ICB.
Director of Finance	The Director of Finance shall be known as the Executive Director of Finance, Resources & Contracts
Director of Nursing	The Director of Nursing shall be known locally as the Executive Clinical Director of Total Quality Management.
Forward Plan Condition	The 'Forward Plan Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Health care professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
Health service body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
Integrated Care Board	Members of the Integrated Care Board (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.
Level of Services Provided Condition	The 'Level of Services Provided Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Medical Director	The Medical Director shall be known locally as the Executive Clinical Director of Utilisation Management.

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 that 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

1.0 Introduction

1.1 These Standing Orders have been drawn up to regulate the proceedings of NHS Central East Integrated Care Board (the ICB) 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.

2.0 Amendment and review

2.1 The Standing Orders are effective from 1 April 2026.

2.2 Standing Orders will be reviewed annually.

2.3 Amendments to these Standing Orders will be made as per section 1.6 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.

3.0 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 governance lead, 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 and Risk Committee for review.

4.0 Meetings of the Integrated Care Board

4.1 Calling Board Meetings

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

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

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.
b) One third of the members of the Board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the Board specifying the matters to be considered at the meeting.
c) In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

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

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

4.2 Chair of a meeting

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

4.2.2 If the Chair is absent or is disqualified from participating by a conflict of interest, the Deputy Chair shall preside over meetings in the Chair's stead.

4.2.3 If both the Chair and Deputy Chair are absent or disqualified from participating by a conflict of interest the assembled members may appoint a temporary Deputy for the purpose of chairing the meeting.

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

4.3 Agenda, supporting papers and business to be transacted

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

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

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

4.4 Petitions

4.4.1 Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the Board in accordance with 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. The deputy may speak but may not vote on their behalf.

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

4.6 Virtual attendance at meetings

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

4.7 Quorum

4.7.1 The quorum for meetings of the Board will be seven of its members, including:

a) Either the Chief Executive, Deputy Chief Executive or the Executive Director of Finance, Resources & Contracts (please refer to paragraph 2.2.3g).
b) Either the Executive Clinical Director of Utilisation Management, or the Executive Clinical Director of Total Quality Management (please refer to paragraph 2.2.3h and i)
c) At least four Executive Members which can include those set out at 4.7.1 (a) and 4.7.1 (b)
d) At least two independent non-executive members which can include the Chair.

e) At least one Partner 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.
c) A nominated deputy permitted in accordance with standing order 4.5 will not count towards quorum for meetings of the board.

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

4.8 Vacancies and defects in appointments

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

4.8.2 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

a) Vacant roles will not be included in the total number.

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 board members and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

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

a) All members of the Board who are present at the meeting will be eligible to cast one vote each.
b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
c) For the sake of clarity, any additional participants and observers (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

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

Urgent decisions

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

4.9.5 The powers that are reserved or delegated to the Board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having been made to consult with as many members as possible in the given circumstances.

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

4.10 Minutes

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

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

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

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

4.11 Admission of public and the press

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

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

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

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

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

5.0 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 Board members.

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

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

6.0 Use of Seal and authorisation of documents.

6.1 The common seal of the ICB shall be kept by the Chief Executive Officer or a nominated manager by them in a secure place.

6.2 Register of sealing
The Chief Executive Officer shall keep a register in which they, or another manager of the ICB authorised by them, shall enter a record of the sealing of every document.

6.3 Use of the seal
Please refer to the Governance Handbook here http://www.centraleast.icb.nhs.uk for details of who may authorise its use, and when use of the seal will be triggered.