



Gloucestershire

NHS Gloucestershire Integrated Care Board

CONSTITUTION

*Version 3
March 2026*

This version of the ICB Constitution has been updated to reflect changes made to the new cluster ICB organisation in particular the appointment of the Executive Structure. The changes made are tracked changed from hereon in.

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1. Introduction

1.1 Background/Foreword

1.1.1 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.

1.1.2 Gloucestershire's Integrated care systems (ICSs) is a partnership of health and care organisations that have come together to plan and deliver joined-up services and to improve the health of people who live and work in Gloucestershire.

1.1.3 We exist to achieve four key aims:

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

1.1.4 Gloucestershire Integrated Care Board and One Gloucestershire Integrated Care System have a shared vision to work together in an inclusive and collaborative way to transform and improve services: Our vision is:

“To improve health and wellbeing of our population, we believe that by all working better together - in a more joined up way, and using the strengths of individuals, carers and local communities - we will transform the quality of support and care we provide to all local people”

1.1.5 The Integrated Care Board (ICB) will work to deliver the strategy and our key strategic priorities set by One Gloucestershire Health and Wellbeing Partnership. In 2019 we set out our ambitions in our five-year plan.

1.1.6 Functions of the ICB

1.1.6i The functions of the ICB and purpose of One Gloucestershire ICS are defined in the ICS Design Framework as detailed in 1.1.5ii. In addition to the four key strategic aims, the 168 statutory functions, duties and powers of CCG's shall be conferred on ICBs as per the Health Act 2006 amended by the Health and Care Act 2022.

1.1.6ii The functions of the ICB are set out in the ICS Design Framework and have been adopted in full and supplemented with locally agreed functions. They are:

1. Developing a plan to meet the health needs of the population;
2. Allocating resources to deliver the plan across the system;
3. Establishing joint working arrangements with partners that embed collaboration as the basis for delivery of joint priorities;
4. Establishing governance arrangements to support collective accountability between partners;
5. Leading system wide arrangements through which the delivery of health services is ensured in line with allocated resources and conforming to national and Constitutional standards;
6. Leading system implementation of the People Plan;
7. Leading system wide action on digital and data;
8. Using joined up digital and data capabilities to understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvement;
9. Working alongside councils to invest in local voluntary sector and community organisations and infrastructure;
10. Driving joint working on estates, procurement, supply chain and commercial strategies;
11. Planning for, responding to and leading recovery from incidents (EPRR);
12. Functions NHS E/I will be delegating – e.g., commissioning of primary care and specialised services;
13. *Promotion of Health and Population Health Management;
14. *Engagement and participation of local people and communities (*locally agreed functions).

This Constitution establishes the principles, statutory duties and governance arrangements of the ICB

It also describes the governing principles, rules and procedures that the ICB will establish to ensure probity and accountability in the day to day running of the ICB, to ensure decisions are taken in an open, collaborative and transparent way and that the interests of patients and the public remain central to the values/aims of the ICB and One Gloucestershire ICS.

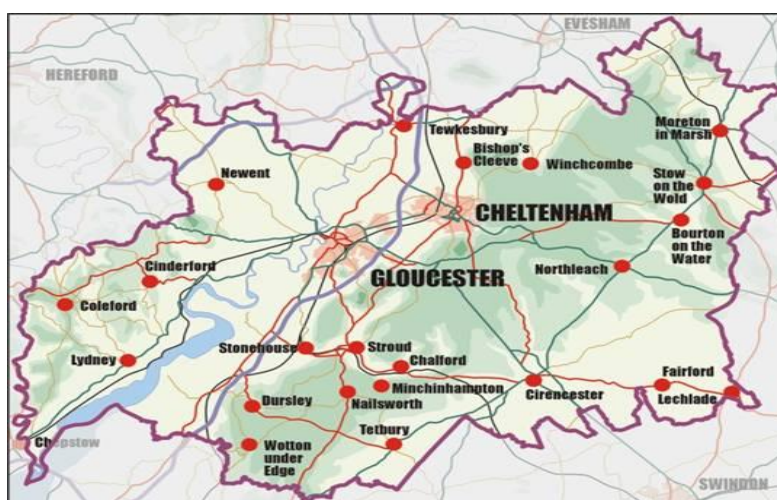
This Constitution applies to all ICB employees, individuals working on behalf of the ICB including anyone who is a member of the Board of the ICB, its sub-committees, joint committees and any other employee or other person working on behalf of the ICB.

1.2 Name

- 1.2.1 The name of this Integrated Care Board is NHS Gloucestershire Integrated Care Board (“the ICB”).

1.3 Area Covered by the Integrated Care Board

- 1.3.1 The area covered by the ICB the Borough of Cheltenham, District of Cotswold, District of Forest of Dean, City of Gloucester, District of Stroud, Borough of Tewkesbury, comprising 271,207 hectares with a population of over **600,000**.



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 <https://nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/icb-constitution/>

- 1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:
- a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);
 - b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
 - c) Duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014);
 - d) Adult safeguarding and carers (the Care Act 2014);
 - e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35); and
 - f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000);
 - g) Provisions of the Civil Contingencies Act 2004.
- 1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.
- 1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under—
- a) section 14Z34 (improvement in quality of services),
 - b) section 14Z35 (reducing inequalities),
 - c) section 14Z38 (obtaining appropriate advice),
 - d) section 14Z40 (duty in respect of research)
 - e) section 14Z43 (duty to have regard to effect of decisions)
 - f) section 14Z45 (public involvement and consultation),
 - g) sections 223GB to 223N (financial duties), and
 - h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).
- 1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).¹

¹ To update with the Health and Care Act 2022 amendment of the 2006 Act to confer on ICBs the functions of primary care commissioning.

1.5 Status of this Constitution

- 1.5.1 The ICB was established on 1st July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its Constitution by reference to this document.
- 1.5.2 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

- 1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:
- a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and
 - b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).
- 1.6.2 The procedure for proposal and agreement of variations to the Constitution shall be as follows:
- a) Upon a recommendation of the Audit Committee as part of the annual review of the Constitution (*see SoRD 1.5 (c) subsection (a)*).
 - b) Upon a recommendation of the Chair and/or Chief Executive included on the agenda for the meeting;
 - c) Recommendations shall be considered by the board provided that the meeting is quorate.
 - d) Provided that any variation or amendment does not contravene a statutory provision, direction made by the Secretary of State or guidance issued by NHS England
 - e) 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 process 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) – 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 or those organisations in accordance with section 65Z6 of the 2006 Act.
 - Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
 - Role profiles for board members;
 - Risk Management arrangements;
 - The up-to-date list of eligible providers of primary medical services under clause 3.6.2.
- e) **Key policy documents** - which should also be included in the Governance Handbook or linked to it – including:
 - Standards of Business Conduct Policy which contains the Conflicts of Interest policy and procedures;
 - Counter Fraud Policy;
 - Health and Safety Policy.

2 Composition of the Board of the ICB

2.1 Background

- 2.1.1 The ICB shall consist of members as set out in sections 2.1.3 – 2.2.3 covering mandated members (as per NHS England policy) and locally agreed ordinary members.
- 2.1.2 Further information about the individuals who fulfil these roles can be found on our website <https://nhsglos.nhs.uk/about-us/how-we-work/the-icb-board/member-profiles/> .
- 2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as “the board” and members of the ICB are referred to as “board Members”) consists of:
- a) a Chair
 - b) a Chief Executive
 - c) at least three Ordinary members.
- 2.1.4 The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB’s functions.
- 2.1.5 NHS England Policy requires the ICB to appoint the following additional Ordinary Members:
- a) three executive members, namely:
 - Chief Financial Officer
 - Chief Medical Officer
 - Chief Nursing Officer

These Executive functions have been incorporated into the jointly appointed Executive Team serving BNSSG and Gloucestershire ICB and the directorate structures reporting to the relevant posts which are:

 - Chief Clinical Leadership & Delivery Officer – Nursing
 - Chief Clinical Leadership & Delivery Officer – Medical
 - Chief Finance & Corporate Services Officer
 - b) at least two Non-Executive Members.
- 2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following and appointed in accordance with the procedures set out in Section 3 below:
- NHS trusts and foundation trusts who provide services within the ICB’s area and are of a prescribed description
 - the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description
 - the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB’s area.

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 five Partner Members.

- a) A member nominated by NHS Foundation Trusts
- b) A member nominated by NHS Foundation Trusts with knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness Learning Disabilities and Autism;
- c) A member nominated by Primary Medical Services;
- d) A member nominated by the Local Authority;
- e) A member nominated by the Local Authority that brings the perspective of Population Health and Prevention.

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

- a) *5 Jointly appointed Non-Executive Members
- b) Chief Population Health Improvement Officer
- c) Chief Strategic Commissioning Officer
- d) Chief Clinical Leadership & Delivery Officer – Nursing
- e) Chief Clinical Leadership & Delivery Officer – Medical
- f) Chief Finance & Corporate Services Officer
- g) Chief Transformation, Organisational Development & People Officer

2.2.3 The board is therefore composed of the following members:

- a) Chair
- b) Chief Executive
- c) 2 Partner member(s) NHS and Foundation Trusts
- d) 1 Partner member(s) Primary Medical Services
- e) 2 Partner member(s) Local Authorities
- f) *5 Non-executive members (one of which, but not the Audit Committee Chair, will be appointed Deputy Chair and one of which, who is the Deputy Chair will be appointed the Senior Non-executive Member)
- g) Chief Population Health Improvement Officer
- h) Chief Strategic Commissioning Officer
- i) Chief Clinical Leadership & Delivery Officer – Nursing
- j) Chief Clinical Leadership & Delivery Officer – Medical
- k) Chief Finance & Corporate Services Officer
- l) Chief Transformation, Organisational Development & People 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 Regular Participants and Observers at Board Meetings

- 2.3.1 At the discretion of the Chair, the board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit.
- 2.3.2 Participants will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote.
- 2.3.3 Observers will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.
- 2.3.4 Participants and / or observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the Standing Orders.
- 2.3.5 Participants will be invited to each meeting of the board and will include:
- a) A participant from NHS Foundation Trusts;
 - b) A participant from NHS Foundation Trust – with the knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness Learning Disabilities and Autism;
 - c) A participant from Primary Medical Services;
 - d) A participant from the Local Authority;
 - e) The Chair of the Integrated Care Partnership, known as One Gloucestershire Health and Wellbeing Partnership.

3 Appointments Process for the Board

3.1 Eligibility Criteria for Board Membership:

- 3.1.1 Each member of the ICB must:
- a) Comply with the criteria of the “fit and proper person test”
 - b) Be committed to upholding the Seven Principles of Public Life (known as the Nolan Principles);
 - c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification;
 - d) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in the role profiles (see Governance Handbook);
 - e) Comply with the requirements of the ICB Standards of Business Conduct policy that includes the Conflicts of Interests policy.

3.2 Disqualification Criteria for Board Membership

3.2.1 A Member of Parliament.

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

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

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

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

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

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

- a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office
- b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings,

- c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest, or
- d) of misbehaviour, misconduct or failure to carry out the person's duties;

3.2.7 A Health Care Professional meaning an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002, or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was—

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

3.2.8 A person who is subject to —

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

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

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

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

3.3 Chair

- 3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State.
- 3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria
- a) The Chair will be independent.
 - b) Fulfil the eligibility criteria set out in the role profile included in the Governance Handbook.
- 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.
 - b) Any of the disqualification criteria set out in 3.2 apply
- 3.3.4 The term of office for the Chair for the first term will be two years and after this first term of office a further two terms may be served for 6 years or three years each. The maximum period of office that the Chair may serve is eight years.

3.4 Deputy Chair and Senior Non-executive Member

- 3.4.1 The Deputy Chair is to be appointed from amongst the non-executive members by the board subject to the approval of the Chair.
- 3.4.2 No individual shall hold the position of Chair of the Audit Committee and Deputy Chair at the same time.
- 3.4.3 The Senior Non-Executive Member is to be appointed from amongst the non-executive members by the board and is the Deputy Chair subject to the approval of the Chair.

3.5 Chief Executive

- 3.5.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.
- 3.5.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.
- 3.5.3 The Chief executive must fulfil the following additional eligibility criteria:
- a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
- 3.5.4 Individuals will not be eligible if:
- a) Any of the disqualification criteria set out in 3.2 apply

- b) Subject to clause 3.4.3(a), they hold any other employment or executive role other than chief executive of another Integrated Care Board;
- c) If they fail to fulfil the eligibility criteria set out in the role profile contained in the Governance Handbook.

3.6 Partner Members - NHS Trusts and Foundation Trusts

3.6.1 These Partner Member 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. Those trusts are:

- a) Gloucestershire Hospitals NHS Foundation Trust;
- b) Gloucestershire Health and Care NHS Foundation Trust;
- c) South Western Ambulance Service NHS Foundation Trust.

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

- a) Be an Executive Director of one of the NHS Trusts or FTs within the ICB's area;
- b) One shall have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness Learning Disabilities and Autism.

3.6.3 Individuals will not be eligible if

- a) Any of the disqualification criteria set out in 3.2 apply;
- b) Failure to comply with the eligibility criteria for board role profiles described in the Governance Handbook.

3.6.4 These member(s) will be appointed by the 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 3.5.1.a will be invited to make 1 nomination.
 - 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 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.
- b) Assessment, selection, and appointment is subject to approval of the Chair under c)

- The full list of nominees will be considered and assessed 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 (the Partner Role Profiles are contained in the Governance Handbook) and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3
 - 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 these Partner Member will be 2 years, followed by 3 years and the total number of terms they may serve is 2 terms. For reasons of continuity a further 1 year may be granted in exceptional circumstances.

3.7 Partner Member - Providers of Primary Medical Services.

3.7.1 This Partner Member is jointly nominated by providers of primary medical services for the purposes of the health service within the 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

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

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

- a) Specify any other criteria set out by NHS England's guidance;
- b) Health professionals who provide primary medical services within the ICB area.

3.7.4 Individuals will not be eligible if:

- a) Any of the disqualification criteria set out in 3.2 apply;
- b) Failure to comply with the eligibility criteria for board role profiles described in the Governance Handbook.

3.7.5 This member will be appointed by the Appointments Panel and 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 described at 3.6.1 and listed in the Governance Handbook will be invited to

make up to 2 nominations to be sent to ICB Corporate Governance Team.

- The nomination of an individual must be seconded by 2 other eligible organisations.
- 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 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, 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 and assessed 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 3.6.1, 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 the 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 2 years, followed by 3 years and the total number of terms they may serve is 2 terms. For reasons of continuity a further 1 year may be granted in exceptional circumstances.

3.8 Partner Members - local authorities

3.8.1 This Partner Member is nominated from the local authority whose area coincide with, or include the whole or any part of, the ICB's area. The local authority is:

- (i) Gloucestershire County Council.

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

- a) Be the Chief Executive or relevant Executive level role of one of the bodies listed at 3.7.1;
- b) One partner member shall bring the perspective of population health and prevention;
- c) Be from a local authority at 3.7.1 which has statutory social care responsibility;
- d) Specify any other criteria set out by NHS England's guidance.

- c) Individuals will not be eligible if
 - a) Any of the disqualification criteria set out in 3.2 apply;
 - b) Failure to comply with the eligibility criteria for board role profiles described in the Governance Handbook;
 - c) and any criteria set out in NHS E guidance

- d) This member will be appointed by the Appointments Panel subject to the approval of the Chair.

- e) The appointment process will be as follows:
 - a) Joint Nomination:
 - When a vacancy arises, each eligible organisation described at 3.7.1 and listed in the Governance Handbook will be invited to make 1 nomination.
 - Eligible organisations may nominate individuals from their own organisation.
 - The eligible organisations will be requested to confirm whether they 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. If they don't, 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 and assessed 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 3.7.1 and 3.7.2
 - In the event that there is more than one suitable nominee, the panel will select the most suitable for the appointment.
 - c) Chair's approval:
 - The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

- f) The term of office for these Partner Member will be 2 years, followed by 3 years and the total number of terms they may serve is 2 terms. For reasons of continuity a further 1 year may be granted in exceptional circumstances.

3.9 Chief Clinical Leadership & Delivery Officer - Medical

- 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 198(4)(b) of Schedule 1B to the 2006 Act;
- b) Be a registered Medical Practitioner;
- c) Fulfil the eligibility criteria set out in the role description included in the Governance Handbook
- d) Specify any other criteria set out by NHS England's guidance.

3.9.2 Individuals will not be eligible if:

- b) Any of the disqualification criteria set out in 3.2 apply;
- c) Failure to comply with the eligibility criteria for board role profiles described in the Governance Handbook;
- d) and any criteria set out in NHS E guidance

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

3.10 Chief Clinical Leadership & Delivery Officer - Nursing

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 198(4)(b) of Schedule 1B to the 2006 Act;
- b) Be a registered Nurse;
- c) Specify any other criteria set out by NHS England's guidance.

3.10.2 Individuals will not be eligible if:

- a) Any of the disqualification criteria set out in 3.2 apply
- b) Failure to comply with the eligibility criteria for board role profile described in the Governance Handbook;
- c) and any criteria set out in NHS E guidance.

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

3.11 Chief Finance & Corporate Services Officer

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

- a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
- b) ;Shall be a qualified accountant and have professional membership / registration
- c) Fulfil the eligibility criteria set out in the role description included in the Governance Handbook

d) and any criteria set out in NHS E guidance.

3.11.2 Individuals will not be eligible if:

- a) Any of the disqualification criteria set out in 3.2 apply;
- b) Failure to comply with the eligibility criteria for board role profiles described in the Governance Handbook;
- c) and any criteria set out in NHS E guidance.

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

3.12 Chief Population Health Improvement Officer

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

- a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
- b) Fulfil the eligibility criteria set out in the role description included in the Governance Handbook and any other criteria set out by NHS England's guidance.

3.12.2 Individuals will not be eligible if:

- a) Any of the disqualification criteria set out in 3.2 apply. Failure to comply with the eligibility criteria for board role profiles described in the Governance Handbook;
- b) Any criteria set out in NHS E guidance.

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

3.13 Chief Strategic Commissioning Officer

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

- a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
- b) Fulfil the eligibility criteria set out in the role description included in the Governance Handbook
- c) and any other criteria set out by NHS England's guidance.

3.13.2 Individuals will not be eligible if:

- a) Any of the disqualification criteria set out in 3.2 apply
- b) Failure to comply with the eligibility criteria for board role profiles described in the Governance Handbook
- c) any criteria set out in NHS E guidance.

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

3.14 Chief Transformation, Organisational Development & People Officer

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

- a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
- b) Fulfil the eligibility criteria set out in the role description included in the Governance Handbook
- c) and any other criteria set out by NHS England's guidance.

3.14.2 Individuals will not be eligible if:

- a) Any of the disqualification criteria set out in 3.2 apply
- b) Failure to comply with the eligibility criteria for board role profiles described in the Governance Handbook
- c) any criteria set out in NHS E guidance.

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

3.15 Non-Executive Members

3.15.1 The ICB will jointly appoint Five Non-Executive Members to serve on the clustered ICB Boards and their committees. One of these members shall be appointed by the Chair as the Deputy -Chair.

3.15.2 These members will be appointed the Chair.

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

- a) Not be employee of the ICB or a person seconded to the ICB;
- b) Not hold a role in another health and care organisation in the ICS area;
- c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee
- d) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee
- e) Specify any other criteria set out by NHS England's guidance.
- f) Can be jointly appointed with another ICB with which GICB is clustering with.

3.15.4 Individuals will not be eligible if

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

- c) Failure to comply with the eligibility criteria for board role profiles described in the Governance Handbook.
- d) and any criteria set out in NHS E guidance.

3.15.5 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. There shall be flexibility for the Chair to confer an additional 24 month term of office to provide continuity in exceptional circumstances where required. After a maximum period of eight years a non-executive member shall stand down to ensure on-going independence.

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

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

3.16 Board Members: Removal from Office

3.16.1 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.

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

- a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance;
- b) If they fail to attend three consecutive meetings unless agreed with the Chair in extenuating circumstances;
- c) If they are deemed to not meet the expected standards of performance at their annual appraisal;
- d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to:
 - i. failing to meet the ICB standards of business conduct;
 - ii. misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position;
 - iii. non declaration of a known conflict of interest;
 - iv. seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise;
 - v. gross misconduct.
 - vi. are deemed to have failed to uphold the Nolan Principles of Public Life;

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

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

3.16.4 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.

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

3.16.6 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.

3.17 Terms of Appointment of Board Members

3.17.1 With the exception of the Chair, 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 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 the Remuneration Committee, which will be constituted such that conflicted individuals can reclude themselves appropriately. The Remuneration Committee Terms of Reference detail the membership that will allow for conflicted members to reclude themselves from decision making; these terms of reference are included in the Governance Handbook.

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

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

4 Arrangements for the Exercise of our Functions

4.1 Good Governance

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

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

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(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 on the ICB website <https://nhsglos.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 of its functions, including those that it has delegated. All those with delegated authority are accountable to the board for the exercise of their delegated functions.

4.5 Functions and Decision Map

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

4.5.2 The Functions and Decision Map is published <https://nhsglos.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;
- 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 and will include the Joint Cluster Board.
- 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 on the ICB website <https://nhsglos.nhs.uk/>
- 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 have:
- a) Terms of Reference that describe the membership of the committee and the sub-committees that report into that committee. The board of the ICB, shall approve committee terms of reference;
 - b) An annual review of their ToRs;
 - c) Amendments and changes to committee ToRs that shall be approved by the board of the ICB;
 - d) Minutes of board committees reported to the board of the ICB at each of its meetings;
 - e) The Chair of the committee of the board be a board member of the ICB;
 - f) The board committee and sub-committees comply with Internal Audit findings and committee effectiveness reviews.
- 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 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 and Deputy Chair) who has the qualifications, expertise, or experience to enable them to express credible opinions on finance and audit matters.

- b) Joint 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 Joint 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 on the ICB website <https://nhsglos.nhs.uk/>

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 on ICB website <https://nhsglos.nhs.uk/>. The Joint Cluster Board will operate as a committee for the clustered ICB Boards ensuring that it operates within permissible, legal delegated limits as set out in the SoRD, and where practical, resources are used efficiently and effectively to fulfil statutory responsibilities placed on ICBs to service their defined populations noting that ICBs continue to maintain sovereign boards until merger.

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 on the ICB website <https://nhsglos.nhs.uk/>

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 is published on the ICB website <https://nhsglos.nhs.uk/>

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 is contained in the ICB's Standards of Business Conduct policy. The policy forms part of the Governance Handbook and is published on the ICB website <https://nhsglos.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. The ICB will publish the registers of interests on its website <https://nhsglos.nhs.uk/>

- 6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.
- 6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of interest Policy and the Standards of Business Conduct Policy.
- 6.1.6 The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:
- a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;
 - b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
 - c) Support the rigorous application of conflict-of-interest principles and policies;
 - d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
 - e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

- 6.2.1 In discharging its functions, the ICB will abide by the following principles:
- a) Conflicts of Interests shall be dealt within in accordance with the ICB's conflicts of interest's policy (contained within the Standards of Business Conduct policy) and NHS England statutory guidance for managing conflicts of interests.
 - b) Recognising that the perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them actually occurring. If in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it. For a conflict of interest to exist, financial gain is not necessary.
 - c) Being proactive, not reactive – the ICB will seek to identify and minimise the risk of conflicts of interest at the earliest possible opportunity for instance by considering potential conflicts of interest when appointing individuals to join the board or other decision-making bodies, and by ensuring individuals receive proper induction and understand their obligations to declare conflicts of interest.
 - d) Being balanced, appropriate and proportionate to the circumstances and context – rules will be clear and robust but not overly prescriptive

or restrictive. They should ensure that decision-making processes are transparent and fair whilst not being overly constraining, complex or cumbersome.

- e) Being transparent – the ICB will document the approach and decisions taken at every stage in the decision-making process so that a clear audit trail is evident.
- f) Creating an environment and culture where individuals feel supported and confident in declaring relevant information and raising any concerns.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

- a) Members of the ICB Board
- 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 <https://nhsglos.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 Standards of Business Conduct policy

(including Conflicts of Interests policy) to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of Business Conduct

- 6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:
- a) act in good faith and in the interests of the ICB;
 - b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);
 - c) comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.
- 6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

7 Arrangements for ensuring Accountability and Transparency

7.1 Accountability

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

7.2 Principles

- 7.2.1 We will act with honesty and integrity and solely in terms of patients and public interests.
- 7.2.2 We will make collective decisions in an open and transparent manner that best serve the interests of our local population in Gloucestershire.
- 7.2.3 We adhere to a collective model of accountability, where we hold each other mutually accountable for respective contributions to shared priorities and strategic objectives.
- 7.2.4 We will demonstrate this by:
- a) holding meetings of the ICB board in public with exception to 7.3;
 - b) board meeting dates, times, venues, and papers will be published on the ICB's website, including notice of the AGM;

- c) holding an Annual General Meeting (AGM) where the Annual Report will be adopted.

7.2.5 We will publish on the ICB website:

- a) Constitution;
- b) Governance Handbook including the SoRD;
- c) Agreed System Plan;
- d) Annual Report inclusive of the annual accounts;
- e) Registers of interests;
- f) Procurement decisions;
- g) Notices of procurements, public consultations, and forthcoming meetings.

7.2.6 Key policies such as the Standards of Business Conduct (conflict of interest's policy) and Complaints Policy, Patient and Public Engagement strategy and policy.

7.2.7 Freedom of Information Publication Scheme - the above documents and notices will also be available on request from the ICB.

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) Standards of Business Conduct Policy including the Conflicts of Interest policy and procedures;
- b) Scheme of Reservation and Delegation;
- c) Standing Financial Instructions;
- d) Registers of interests;
- e) 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 plan will explain how the ICB proposes to discharge its duties under:
- sections 14Z34 to 14Z45 (general duties of integrated care boards); sections 223GB and 223N (financial duties) proposed steps to implement the Gloucestershire Joint Local Health and Wellbeing Strategy.
 - set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 2.
 - 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 complying with existing procurement rules until the provider selection regime comes into effect. This will also include:
- a) evidencing that it has properly exercised the responsibilities conferred on it by the regime by:
 - publishing the intended selection approach in advance;
 - publishing the outcome of decisions made and the details of contracts awarded;
 - b) 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;
 - c) recording how conflicts of interest were managed;
 - d) monitoring compliance with this regime via an annual internal audit processes the results of which will be published;
 - e) including in the annual report a summary of contracting activity as specified by the regime;
 - f) 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 Joint Remuneration Committee which is chaired by a non-executive member other than the Chair or Audit Chair.

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

- a) Professional Human Resources advice and support;
- b) Professional advice on remuneration frameworks;
- c) Legal advice from the ICB's lawyers in relation to employment law.

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

8.1.5 The main purpose of the Joint 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 <https://nhsglos.nhs.uk/>

- 8.1.6 The duties of the Joint Remuneration Committee include
- a) Agreeing the ICB salaries policy and standard terms and conditions for employees;
 - b) Setting remuneration, allowances, terms and conditions for board members;
 - c) Setting any allowances for members of committees and sub-committees of the ICB who are not members of the board.
- 8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff in line with the ICB Secondment Policy.

9 Arrangements for Public Involvement

- 9.1.1 In line with section 14Z54(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:
- a) the planning of the commissioning arrangements by the Integrated Care Board;
 - b) the development and consideration of proposals by the ICB;
 - c) for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them, and
 - d) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.
- 9.1.2 In line with section 14Z54 of the 2006 Act the ICB has made arrangements to consult its population on its system plan in line with its policy on Public Involvement.
- 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;
- 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 In addition, the ICB has agreed the following arrangements, including:

- a) implementing a system-wide strategy for working with people and communities which will ensure adoption of the 10 principles throughout Gloucestershire;
- b) working with partners across the ICS to develop arrangements for ensuring that the Integrated Care Partnership (ICP) and locality-based partnerships continuously engage with local people and in developing, reviewing and evaluations strategies and plans;
- c) gathering intelligence about the experience and aspirations of people who use care and support and embedding clear approaches to using these insights to inform decision-making and system governance;
- d) publish our Working with People and Communities Strategy on the ICB website and confirm our commitment to adopting the ten national principles within the Governance Handbook.

9.1.6 The ICB will ensure that ICS partners adopt an integrated approach to communications, using established and innovative methodologies and infrastructure. This will:

- a) ensure One Gloucestershire ICS applies best practice principles in developing its communication and engagement infrastructure and associated activity;
- b) ensure the One Gloucestershire ICS strategic plans and programmes are supported by comprehensive communications and involvement activities tailored to the needs of each audience.

9.1.7 The ICB will establish and maintain a range of opportunities for the following groups (a-f) to inform the development and delivery of the system-wide strategy for working with people and communities:

- a) Local residents, people who access care and support (and those who do not), unpaid carers and families;
- b) Healthwatch;
- c) VCSE partners;
- d) Leaders in our system who will champion and embed this work;
- e) Involvement, experience and communications practitioners employed by all system partners;
- f) NHS non-executives, foundation trust members and governors, local government councillors.

9.1.8 The ICB strategy, plans and involvement activities will build on existing local good practice derived from the approaches of ICS partners, as well as seeking to drive innovation and new knowledge in public and community involvement.

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
ICB board	Members of the ICB
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this Constitution
Committee	A committee created and appointed by the ICB board.
Sub-Committee	A committee created and appointed by and reporting to a committee.
Forward Plan Condition	The 'Forward Plan Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance
Level of Services Provided Condition	The 'Level of Services Provided Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
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.
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: <ul style="list-style-type: none"> NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description

	<ul style="list-style-type: none"> 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.
Chief Clinical Leadership & Delivery Officer Medical	An individual who is appointed to the ICB and who will fulfil the NHSE policy requirement to appoint a Medical Director
Chief Finance & Corporate Services Officer	An individual who is appointed to the ICB and who will fulfil the NHSE policy requirement to appoint a Director of Finance
Chief Clinical Leadership & Delivery Officer - Nursing	An individual who is appointed to the ICB and who will fulfil the NHSE policy requirement to appoint a Nursing Director
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.'
Eligible organisations	This refers to all partner members eligible to nomination for a given partner appointment. Eligible nominators are listed in sections 3.5.1 and 3.7.1
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
<i>The ICB will add local definitions as required and always include any local terms that refer to legally prescribed roles or functions.</i>	

Standing Orders

1. Introduction

- 1.1. These Standing Orders have been drawn up to regulate the proceedings of NHS Gloucestershire 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 01 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 1.6 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. 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 Committee for review.

4. Meetings of the Integrated Care Board

4.1 Calling Board Meetings

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

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

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

4.1.3. A public notice of the time and place of the meeting 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. The Chair of the ICB shall appoint a Deputy Chair who will be one of the Non-Executive Members

4.2.2 If the Chair is absent or is disqualified from participating by a conflict of interest, the Non-Executive Deputy Chair if present shall preside. If both the Chair and Deputy Chair are absent or are disqualified from participating by a conflict of interest, then a member of the Integrated Care Board shall be chosen by the members present, or by a majority of them, and shall preside.

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, in discussion with the Chief Executive.

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 <https://nhsglos.nhs.uk/>

4.4 Petitions

4.4.1 The board shall receive questions from the public at least 3 calendar days before the board meeting. Questions will be submitted in line with the ICB's protocol for public questions, deputations and petitions which is available on the ICB's website. The Corporate Governance Department shall establish and maintain this protocol.

4.4.2 Where a petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the board.

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 and vote on their behalf.

4.5.2 The substantive office holder shall confirm their nomination of a deputy in writing to the person presiding over the meeting in advance of the meeting.

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

4.6 Virtual attendance at meetings

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

4.7 Quorum

4.7.1 The quorum for meetings of the board will be at least 50% of the members, including:

- a) Either the Chief Executive or the Chief Finance & Corporate Services Officer
- b) At least one Non-Executive Director
- c) At least one Partner Member.

4.7.2 For the avoidance of doubt:

- 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 is permitted in accordance with standing order 4.5 and will 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: The quorum will be based on 5 members to include:

- a) Either the Chief Executive or the Chief Finance & Corporate Services Officer;
- b) At least one Non-Executive Director;
- c) At least one Partner Member.

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working through 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. Where required the Chair shall have a casting vote.
- 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 paragraphs 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.

4.9.3 Disputes - 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.

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

4.9.5 The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having made to consult with at least 50% of the members, including

- Either the Chief Executive or the Chief Finance & Corporate Services Officer
- At least one Non-Executive Director, including the Chair of Audit or Deputy Chair of Audit
- At least one Partner Member

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 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 suppress or prevent disorderly conduct or behaviour.

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

5. Suspension of Standing Orders

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

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

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

6. Use of seal and authorisation of documents

6.1 The ICB shall have a seal for executing documents where necessary.

6.2 The following individuals or officers are authorised to authenticate its use by their signature; two signatures are required to do so, one of which is to be either the Chief Executive or the Chief Financial & Corporate Services Officer:

- a) Chief Executive;
- b) the Chair of the Integrated Care Board;
- c) the Deputy -Chair of the Integrated Care Board; and
- d) the Chief Finance & Corporate Services Officer.

6.3 The following individuals are authorised to execute a document on behalf of the ICB by their signature; two signatures are required to do so, one of which is to be either the Chief Executive or the Chief Finance Officer:

- a) Chief Executive;
- b) the Chair of the Integrated Care Board;
- c) the Deputy -Chair of the Integrated Care Board; and
- d) the Chief Financial Officer.