Our Healthier South East London
Integrated Care System

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Development of SEL ICB Constitution

Feedback and responses

March 2022

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Introduction and Purpose

What is the constitution?

- Each Integrated Care Board (ICB) is required by law to have a constitution ahead of its establishment, pending legislation on 1 April 2022.
- The constitution is a legal document outlining the high level governance structures and responsibilities of the ICB and includes the ICB's standing orders.
- The constitution is important because it outlines how the ICB will discharge its functions, recruit to the board and make decisions. therefore it is critical that the partners across the ICB are appraised of and can contribute to the development of its content
- Anything included in the constitution needs to be adhered to and cannot be changed without a formal process and approval from NHSE/I
- NHSE/I provide a model constitution to use with an expectation that particular elements (writing included in black) is not changed.

Engagement on this document and next steps

- The majority of the document is nationally prescribed, but we are committed to engaging with partners to ensure all possible localisation is made and our document works for us
- The draft ICB constitution was shared with partners on the 10 November 2021
- We have held a number of engagement sessions, attended stakeholder meetings and invited comments through other mechanisms (see next slide)
- A draft following comments was submitted to NHSE on 3rd December 2021
- NHS comments were received pre-Christmas
- Engagement continued throughout January and a revised draft constitution was submitted to NHSE on 25th February 2022

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What engagement has looked like

Feedback
received via engagement meetings and email

>130
Stakeholders invited to 3 engagement drop in sessions

>12
Different stakeholder groups engaged with

- Primary care leadership group members
- ICS Executive
- PCN Clinical Directors
- LA leaders and CEOs
- DASs
- Trust Chairs and CEOs
- LMC
- Directors of Public Health
- CVS
- Healthwatch leads
- LCP members
- Lambeth stakeholders

> 60
Pieces of feedback and questions received

> 20
Attendees joined drop in sessions

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What engagement has looked like

Feedback process undertaken

1. We held 3 “drop in” sessions during November for stakeholders to ask questions or feedback on the contents of the constitution. These were attended by a number of people including councillors, GPs, members of Local Care Partnerships, providers and Borough Directors
2. In addition to both responding to and capturing the questions and comments, people were also invited to submit comments by email
3. We offered to all parties our attendance at other meetings or have one to ones to discuss any comments
4. Further engagement sessions were arranged during January

Meetings where engagement on the draft constitution took place:

- 3 engagement drop in sessions (15,16, 25 Nov)
- Lambeth Stakeholders (19 Nov)
- Primary care leadership group meeting (24 Nov)
- SEL ICS Exec (24 Nov)
- LA Chief Executives (25 Nov)
- Voluntary Sector (30 Nov)
- Joint SEL CCG executive with DASS (3 Dec)
- Trust Chairs (12 Dec)

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Feedback

What we have heard (main themes)	What we have done in response
The majority of those who provided feedback made clear that they were in support of the amendable and interesting areas of the draft constitution. It is clear to see why the constitution has been kept “light”	No action required for these areas of feedback. It has been noted that overall, the response to the draft constitution has been really supportive and no major objections have been raised
A description of the relationship between the ICB, ICP and LCPs needs to be included in the constitution	The foreword has been expanded and a specific clause added to section 4 – Arrangements for the Exercise of Our Functions, to articulate these relationships
A description of the primary care leadership group has not been currently described in the draft constitution	A description has been included in the constitution glossary describing the primary care leadership group
Wording for how changes can be made to the scheme of reservation and delegation (SoRD) to be made clearer and more robust	The model constitution wording already includes (clause 4.4): “Only the Board may agree the SoRD and amendments to the SoRD may only be approved by the Board”. This is correct as the board remains accountable for all of its functions including those that it has delegated. No change is therefore proposed.
Wording for terms to be made flexible for partner members so that members can be rotated e.g. annually if the group wants to (with particular reference to primary care member)	Engagement will continue on this aspect of the constitution

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Feedback

What we have heard (main themes)	What we have done in response
Section 1.6.2 states that "any proposed changes received will be considered annually…" perhaps this should be amended to "**at least** annually"	The ICB engaged on the constitution throughout November, prior to submission of the draft, and continued engagement beyond this. As such it is hoped that the final constitution will be robust. In addition, the ICB has kept the document as slim as possible, with most associated documents kept outside of the constitution, so that changes can be made more regularly to these if required. It would also not be considered good governance to regularly change an organisation's constitution and NHSE have advised that the word annually should not be included. The wording of this section has therefore been revised for NHSE's comments.
Consideration of including participants and observers details in the constitution over time	It is felt sensible to be silent on this point in the constitution so that participants and observers can be changed as required for the needs of the board. As the ICB's board meetings are in public, there is nothing to prevent any member of the public attending a board meeting and asking questions of the board if they wish.

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Feedback

What we have heard (main themes)	What we have done in response
Consideration of the ability to have deputies attending the board so that the voice of the health system is around the table	The ICB's board, committee and sub-committee meetings will be set annually so that all board members are aware of their commitments. The nominated and selected board members, who are personally accountable, are expected to attend all board meetings and the onus is on the board member to attend. Accepting that not all members will be able to attend all board meetings, the constitution includes 50% quoracy with 50% membership expected from each type of member. In the case of long-term sickness, it is expected that stakeholders will re-consider their board member and instigate either a temporary replacement or acting arrangements who will then attend the meetings. With the above mitigations and the importance of seniority and consistency in the board membership, the inclusion of deputies is therefore not considered necessary.
The constitution includes the ability for the chair to remove a board member from office if in their opinion "they fail to meet satisfactory performance standards". It is unclear to what standards members are being / will be held to.	Further detail has been included to make this clearer including referencing this to section 3.1 of the constitution which outlines the expectation of members to follow the Nolan principles, comply with fit and proper person expectations, and fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification and regular non-attendance at meetings

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Feedback

What we have heard (main themes)	What we have done in response
The nomination and selection process for members is reliant on agreement between stakeholders. There is nothing included regarding dispute resolution. What therefore happens if there is a dispute?	The nomination and selection processes have been significantly changed following NHSE feedback and dispute resolution will not now be needed
Can the exclusion of Local authority members be clarified further so that it is clear that this refers to elected councillors	The model constitution has now been changed and this is no longer included
It should be made clear that partners have to commit to confronting social determinants that influence health	More on this commitment has been included in the foreword
Section 1.6.2 says that "any member of the ICP can propose a change to the constitution. This needs to be in writing to the ICB's chief of staff". The ICS may not always have a chief of staff so might be better to contact the Chair.	This section has been changed following NHS feedback and now includes states that proposals are in writing to the ICB's chair or Chief Executive who will pass on to the ICB's governance department.
Does the member role apply to the individual or the CEO role? E.g. if the CEO changes for an organisation, does the new CEO take up the member role on the ICB board and continue term or do they start a new term of office? If the constitution is still in place in 12 years time and each organisations' CEO has completed 6 years, what happens then?	The constitution has been amended to include "Should the selected member leave their Chief Executive role, a new nomination and selection process will take place."

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Feedback

What we have heard (main themes)	What we have done in response
Definitions of the terms LCP and APC: would recommend not being so specific in a document that can only be changed annually	Thank you for your comment. We have had significant comment regarding the importance of recognising these groups and therefore propose to leave these in
On decision making (section 4.9), to aid transparency it is suggested that an updated log of Chair's actions/urgent decisions should be published in advance of the next formal meeting.	The ICB is expected to have very few chair's actions / urgent decisions but needs to have the ability to make them if required. The actions will be published in the board papers prior to the board meeting in accordance with the timescales laid out in the constitution
Please clarify whether the conviction within the UK also requires an outcome of a sentence of imprisonments (whether suspended or not) for a period of less than three months without the option of a fine in order to meet the disqualification criteria.	This is wording provided in the model terms of reference by NHS England. They have clarified that this refers to convictions inside and outside the UK: "**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."

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What we have heard (main themes)	What we have done in response
Scrutiny and decision making (section 7.0): It is noted that ICBs will need to publish their intentions for arranging services in advance. What are the ICBs commissioning plans and the process for developing and assuring those plans? How will the ICB consult on the development of its provider selection policy and how will LMCs be engaged? How will the scrutiny and challenge mechanisms be subject to consultation. How will these mechanisms work with delegated functions?	The ICB does not currently exist so there are no existing ICB commissioning plans. The Integrated Care Partnership will be responsible for agreeing a health and care strategic plan and the Integrated Care Board for determining the actions required to support delivery of this plan across the partners, comprising the ICB alongside the development of strategic and operational plans to meet wider priorities, such as national planning guidance, system and local objectives and outcomes. The process for developing plans will be inclusive with the participation and engagement of partners in planning processes alongside patient and public engagement. The process detail will need to be worked through in the context of national planning processes and deadlines, noting 2023/24 will be the first planning process overseen by the ICB. The ICB will ensure decisions in relation to provider selection are made openly and transparently and in line with the NHS Provider Selection Regime and our associated ICB policy. Our expectation is that proposals and subsequent recommendations will go through appropriate ICB governance arrangements, noting whilst these are not at this point finalised overall accountability will rest with the ICB CEO/ICB. These principles will apply to the arranging of all services whether the delivery responsibility sits with the ICB's Local Care Partnerships as part of agreed delegation arrangements or at system level. Local Authority overview and scrutiny mechanisms will remain a feature of the system post 1 April 2022 and will work in the same way as currently, with both borough level overview and scrutiny and a SEL overview and scrutiny process for pan borough issues, noting our planned delegation to place is in line with existing delegation arrangements.

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What we have heard (main themes)	What we have done in response
It is critical that general practice and GPs are fully engaged so that the perspective of General Practice providers can inform the decision making process. It is requested that LMC representatives are invited as non-voting participants and have opportunities to ask questions and address the meeting. It is requested that an expectation is established that GP providers are invited to subcommittees and task and finish groups throughout the ICS where matters impacting on primary care are being discussed or which may form recommendations to bodies accountable to the ICB.	It is important to note that Primary Care is represented at the ICB's board by a voting member – which enables the perspective of general practice to be included in the meetings. The constitution is deliberately silent on any other observers as this provides flexibility as the ICB develops. Additional attendance at formal ICB meetings will therefore be considered as part of the next phase of ICS development. It is very much intended that GP Providers are actively involved in all aspects of the work of the ICS. Work on how to ensure primary care makes a full contribution to the ICS is currently being undertaken on behalf of the current Primary Care Leadership Group – with support from Prof Becky Malby & Nick Downham - Health Systems Innovation Lab, LSBU. There is LMC representation on the group leading this work
The responsibility for each function needs to be clear and that the ICB will have the capacity to carry them out effectively. This includes what statutory functions will be delivered at ICS or place level where it is for local determination	The functions of an ICB are largely the same as for the CCG insofar as their operation at south east London or borough level goes. The alignment of functions to borough and south east London level will remain as they are now following the detailed piece of work undertaken to ensure effective use of capacity when the six CCGs were merged into one.

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What we have heard (main themes)	What we have done in response
Variation to the constitution: Constitutions need to be adaptable to local conditions and changing circumstances, as well as able to change provisions that do not work well in practice. However there needs to be a clear process for agreeing such variations which include perspectives beyond the partner members. It is suggested that there is a wider consultation on proposed changes and any subsequent variations which includes SEL LMCs. Who is the Chief of Staff?	The proposed process for changes is included in the constitution and has been amended in the latest draft following NHSE feedback. The Chief of Staff is an executive role in the ICB. However, the process now includes any proposed changes being notified to the ICB Chair or chief executive who will pass them to the ICB's governance department.
Register of interests: How will the register be managed, who holds responsibility? It is important that the register is easy to access and it is suggested that it is also included in board papers.	Details regarding the ICB's conflicts of interests policy will be included within the standards of business conduct policy which will form part of the governance handbook. The register of gifts and hospitality is maintained by the governance team who formally record the declarations of all officers. The register of interests for ICB members will be published on the ICB's website and is therefore easily accessible. A register of interests of Board / committee members will also be included in the papers for meetings for which they are a member.

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The related documents are clearly important to the way the ICS operates in practice. Further clarity is requested on: • The status of the related documents and how they relate to the ICB constitution, ICP and LCP. • The consultation process for developing related documents and timeframes. • The approvals process for related documents and process for proposing, consulting on and agreeing variations.	The ICS is currently working through the proposed governance for the ICB, including updating policies and writing terms of reference. These are outside of the constitution and will be published in the ICB's governance handbook. These additional policies and processes will be subject to review by the partnership through the ICB and other decision making forums – where primary care will be represented.
Regarding delegation to place how will decisions regarding the allocation of funding to place be made and what is the scrutiny and challenge process.	The SEL Integrated Care Board (ICB) will be responsible for agreeing the allocation of funding, in line with ICB agreed strategic and operational priorities as well as national planning guidance and funding requirements. This will include the allocation to place with the place allocation covering those services for which delegated responsibility has been agreed. The allocation of funding will form part of the ICB's overall planning process which will be conducted openly and transparently with decisions being taken at the Integrated Care Board, which will include representation from across the Integrated Care System and its stakeholders. The ICB's decisions will also be subject to assurance from London Region to test that national planning requirements have been adhered to. Clarity on delivery responsibilities will be part of the delegation agreement and relevant terms of reference.

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What we have heard (main themes)	What we have done in response
How will the levelling up agenda be reflected in the financial decision making process.	The financial decision-making process will focus on meeting national planning requirements and expectations, ensuring that investment supports the delivery of agreed strategic and operational priorities and that we are addressing unwarranted variation in the level of investment across boroughs and services where there is demonstrable misalignment across weighted population need and associated investment. These factors and how they have influenced the allocation of the ICB's funding decisions will be set out and considered openly and transparently as part of the ICB's planning process.
How will the ICB have regard to the financial viability of its providers and how would this impact on decision making. Will provider sustainability be part of the ICB-LCP reporting and assurance process. How will conflicts between the ICPs Integrated Care Strategy and provider financial sustainability be managed. If delegated decisions regarding the use of ICB funds at place level threaten the viability of providers what is the disputes and appeals mechanism? How will the effects of decisions by the ICB be monitored in order to inform the annual financial plan.	As is the case now, there will be reporting and processes in place to be clear on funding available, proposed utilisation and any known risks and impacts.

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Feedback

What we have heard (main themes)	What we have done in response
• Committees and subcommittees: It is important to ensure that GP perspectives are sought throughout the ICB decision-making structure. In addition, how will LMCs be consulted on the TOR for committees (LCPs) and subcommittees. • How will members of committees and subcommittees be renumerated. Will there be resources to support GP engagement with task and finish groups. • How will recommendations to committees and subcommittees be formed and how will LMCs be consulted early/involved? • If LCPs are committees of the ICB accountable to the ICB and are subject to a reporting and assurance arrangements please explain the level of autonomy that is expected and how this will be reflected in the ToR and reporting and assurance process. • Please explain the role and authority of the LCP Chair and whether a role description will be provided.	The ICB is currently considering its governance structure and members of committees. These will be agreed by the ICB board. There is a full programme of professional and clinical leadership in discussion, which will be remunerated, and will ensure engagement of a wide range of clinical professionals throughout the ICB's business. The delegation afforded to committees and sub-committees, by the ICB board, will be included within the ICB's scheme of reservation & delegation, published as part of the governance handbook. The TOR will include committee membership, roles, responsibilities, relevant assurance and reporting expectations. The role descriptions for local roles (like LCP chair) will be developed locally (at place level)
Section 3.10.6: "*The term of office for this Partner Member will be 3 years and the total number of terms they may serve is 2 terms.*" Is that the same term length as a Place-based Lead?	The place based members are now ordinary members and the term has been changed to "The term of office for these Ordinary Members will be the duration of their employment in this role."

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Integrated Care System

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Feedback

What we have heard (main themes)	What we have done in response
Section 4.1: Should there be a minimum number of board meetings specified per year?	The draft constitution currently states “Meetings of the Board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.” This is from the model TOR provide by NHSE, ensures flexibility is retained and accords with UK corporate governance regulations that require a board to meet “sufficiently regularly to discharge its duties effectively”. It is however expected that public board meetings will be held 6 times a year – every other month.
Board papers: Sending agenda and papers only 5 calendar days before meeting is a short timeframe. Would 7 Calendar days be more appropriate?	The Healthy NHS Board 2013 governance guidance recommends Board papers are shared a week before the meeting, which is the standard applied now by the CCG.
Will the ICB publish the number of meetings members have attended? Local authorities do this.	This would support the drive for transparency. The governance team will be able to maintain a list of meeting attendees and provide a table at the end of the year for publishing in the annual report.

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Feedback

What we have heard (main themes)	What we have done in response
Please provide details of the optional clauses and the rationale for removing them from the constitution. In particular: • Local eligibility/disqualification criteria – have these been removed or has the option to include them been declined? • Local assurance arrangements • Register of interests of decision making staff (including gifts) why has this been removed? It would be reasonable for such a list to be publicly available beyond 6 months.	The details of the optional clauses were included in the letter and supporting documentation sent to stakeholders at the start of the engagement process. Local eligibility / disqualification criteria were for local determination and have not therefore been included. It is felt that the standard eligibility and disqualification criteria is sufficient. The local assurance arrangements for committees and sub-committees will be included in the relevant TOR. The ICB's arrangements for dealing with declarations of interests and the register will be included in the ICB's Standards of Business Conduct policy and there is therefore no need to include the reference in the constitution.
"*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.*" We would recommend reinstating this paragraph as it allows for succession planning and continuity.	This is not considered a necessary clause as succession planning and continuity can be handled outside of the constitution.

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Feedback

What we have heard (main themes)	What we have done in response
• What is the membership and ToR of the Primary Care Leadership Group and its relationship with the ICB? • It is noted that 3.8.1 suggests that the member should be drawn from the primary medical services (general practice) providers with the South East London ICB area. This suggests that a general practitioner would be best placed to fulfil this role. Should the eligibility criteria be explicit on this. • What will be the arrangements for remuneration for partner members and how will this be resourced. • It is requested that the ICS clarify the role and status of the Primary Care Leadership Group in addition to the process for determining its governance. LMCs can bring a valuable perspective to this group and would expect to be formally engaged. What is the effect of a vacancy and the process for securing a delegate?	The TOR for the Primary Care Leadership group are currently under development as current TOR are out of date. There is no national expectation that the Primary Medical Services representative is a GP. GPs must be nominators (this will be set out in secondary regulations with eligibility criteria), but the nominee does not have to be a GP. The role as a board member is not a remunerated position The CCG (as the body responsible for devising the constitution) and the ICB (to which it relates) are committed to supporting primary care to develop a model for primary care leadership in order that they can make a full contribution to the ICS/ ICB, as well as conducting a nomination and selection process which is fair, transparent and in keeping with both best practice, our values and NHS England expectations or requirements. It has been agreed, as part of the current primary care leadership group, that South Bank University would be commissioned to provide a programme of work in support of this and Becky Malby has attended various meetings to describe the approach and progress being made. It was also agreed by the group that a small co-design group would be formed from nominations from each of the boroughs to work with Becky and her team. This work is currently underway and aims to be completed by the new year. The outcome and recommendations of the group will be shared and will inform the future scope, membership and approach that the PC leadership group will take. As part of this we will of course take account of the comments here.

Our Healthier South East London
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Feedback

What we have heard (main themes)	What we have done in response
What is the effect of a vacancy in the Partner Member - Providers of Primary Medical Services and the process for securing a delegate?	Please refer to the answer on deputies and proxy voting.
3.2 Disqualification Criteria for Board Membership 3.2.1 A Member of Parliament, or member of the London Assembly. 3.2.2 A member of a local authority in England and Wales or of an equivalent body in Scotland or Northern Ireland Could add in elected to be clearer or clarify in terminology section	This clause has now been changed in the NHSE model TOR to remove member of the London Assembly and a member of a local authority

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Feedback

What we have heard	What we have done in response
Further information is requested regarding the nomination and selection process for the Primary Care Leadership groups appointment of the Partner Member. It is important that GPs have confidence in the appointment and are assured that there is a robust and transparent process for their appointment.	Following NHS England feedback the recruitment process for the partner members is now proposed as follows: 3.6 **Partner Member - Providers of Primary Medical Services** 3.6.1 This Partner Member is nominated by providers of primary medical services for the purposes of the health service within the integrated care board's area, and will be selected from primary care providers within the South East London ICB area 3.6.2 This member must fulfil the eligibility criteria set out at 3.1 3.6.3 Individuals will not be eligible if: a) Any of the disqualification criteria set out in 3.2 apply 3.6.4 This member will be appointed following the appointment process detailed in section 3.6.5. 3.6.5 The appointment process will be as follows: • The ICB will create role descriptions for the Partner Member – Providers of primary medical services, which will set out the requirements associated with the roles, the expected skills, knowledge and expertise that is necessary, and the term of office • The ICB will issue the role descriptions to all holders of a contract for core primary care services, who also hold a list of registered patients with a timeline for a nomination and selection process. Nominations should be accompanied by a brief statement setting out how the candidate meets the requirements of the job role. • Eligible organisations will be asked to confirm their joint agreement to the full list of nominees, to be formally proposed to the ICB; this constitutes jointly nominating all nominees for consideration for appointment by the ICB and chair. All nominating organisations will be contacted and asked whether they support the list of nominations to be submitted, with nil replies being counted as agreement; a simple majority of eligible partners supporting the list will be sufficient to submit it to the ICB for selection. • If agreement cannot be reached the nomination process will be re-run. • Nominated candidates will be shortlisted against the skills, knowledge and experience required to fulfil the role. • The ICB board will arrange a selection panel who will interview each of the jointly nominated candidates for the partner member role. This panel will be supported by a HR professional. • The ICB board selection panel will make a recommendation to the chair of the ICB. • The chair of the ICB will approve the appointed partner member(s). • The chair of the ICB will report the appointed partner member(s) to the next meeting of the ICB board. 3.6.6 The term of office for this Partner Member will be 3 years and there will be a re-appointment process at the end of this 3-year term. 3.6.7 Should the selected member step down prior to the completion of their term a new nomination and selection process will take place.

Our Healthier South East London
Integrated Care System

NHS

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What we have heard (main themes)	What we have done in response
Suggest specifying boroughs included in SEL	These have now been included
Section 1.6.2(b) Any proposed changes received will be considered annually by the chief of staff and a proposal for changes presented back to the integrated care partnership (ICP): Amendments to the Standing Orders can be proposed at any time, and we suggest that the same applies here to afford greater flexibility than an annual review. Proposed changes should be considered by the Chair as a statutory postholder	As suggested reference has been changed to the ICB's chair or chief executive who will pass on to the ICB's governance department. The proposed process has been amended following NHSE feedback.and it should be noted that NHS England has now advised not even to commit to an annual review. The standing orders are an appendix to the constitution and can therefore only be changed at the same time as the constitution. The board will need to consider and approve changes before them being sent to NHSE for approval.
Section 3.10.1/2: "*These members [6 Place Members] will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria* • *Be a Chief Executive or Executive Director of one of the organisations within the relevant borough's local care partnership (LCP) holding executive responsibility for delegation to that place*" We are assuming this means the Place-Based Lead; it would be useful to confirm the terminology.	It is with each borough to determine who fulfils this role; as long as it is within the criteria outlined here. Therefore it may be the place based lead or perhaps another role as long as it has delegation responsibility as outlined

Our Healthier South East London
Integrated Care System

NHS

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Regarding sections: • *3.5.4 This member will be appointed by agreement of the acute providers detailed in section 3.5.1 subject to the approval of the Chair* • *3.6.4 This member [Mental Health Partner] will be appointed by agreement of the mental health services providers detailed in section 3.6.1 subject to the approval of the Chair* • *3.6.5 The mental health services providers named at 3.6.1 will nominate and select the partner member – mental health services, taking account of the skills, knowledge and experience required to fulfil the role* • *3.7.4 This member [Community Health Services] will be appointed by agreement of the community health services* • *3.7.5a The community health services providers named at 3.7.1 will nominate and select the partner member – community health services, taking account of the skills, knowledge and experience required to fulfil the role.* • *3.8.4 This member [Primary Care] will be appointed by the Primary Care Leadership Group subject to the approval of the ICB Chair* • *3.8.5(a) The Primary Care Leadership Group will nominate and select a chair of their group whose role will include fulfilling the role of partner member – primary medical services, taking account of the skills, knowledge and experience required to fulfil the role* Recognising that the Bill states that the partner members are to be 'nominated jointly' by their respective sector, there is no provision for how this will work in practice, and if consensus cannot be reached / there is disagreement. Would be good to have even a light touch dispute resolution process (if possible!).	These sections have been revised following NHSE feedback and include provision for joint nominations.

Our Healthier South East London
Integrated Care System

NHS

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What we have heard (main themes)	What we have done in response
Regarding sections: • *3.9.4 This member [Local Authorities] will be appointed by agreement of the local authorities detailed in section 3.9.1 subject to the approval of the Chair 3.9.5 (a) The local authorities named at 3.9.1 will nominate and select the partner member – local authorities, taking account of the skills, knowledge and experience required to fulfil the role.* recognising that the Bill states that the partner members are to be 'nominated jointly' by their respective sector, there is no provision for how this will work in practice, and if consensus cannot be reached / there is disagreement. Would be good to have even a light touch dispute resolution process (if possible!).	This section has been revised following NHSE feedback and include provision for joint nominations.
3.10.5 The relevant borough's local care partnership will nominate and select the partner member – place, taking account of the skills, knowledge and experience required to fulfil the role. Assuming it is the Place Based Lead?	It is with each borough to determine who fulfils this role; as long as it is within the criteria outlined here. Therefore it may be the place based lead or perhaps another role as long as it has delegation responsibility as outlined
"*In discharging its functions the ICB will abide by the principles included in the ICB's Standards of Business Conduct Policy*" Principles and conduct may be slightly different things, but without sight of the Conduct Policy, we cannot comment.	Thank you for your comment which will be considered in development of the policy

Our Healthier South East London
Integrated Care System

NHS

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What we have heard (main themes)	What we have done in response
6.4.1(c) comply with the ICB Standards of Business Conduct Policy which includes the requirements for managing conflicts of interest This wording is not the same as the model constitution (and is not an editable section): comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.	The ICB does not have a separate conflicts of interest policy which is included as part of the standards of business conduct policy. Consequently, the standard wording had to be changed. However, the wording has now been made clearer.
Glossary - Provider Collaboratives are collaborative arrangements that take responsibility for the planning, delivery and improvement of services on an area basis where there is benefit in adopting a collaborative rather than a by provider approach. SEL has a provider collaborative for acute services (the Acute Provider Collaborative) and for mental health (the South London Partnership). Provider Collaboratives form part of the formal system architecture and governance of the Integrated Care Body and Integrated Care System Would recommend not being so specific in a document that can only be changed annually The description of the South London Partnership as the PC for mental health could be read as if it is for all mental health services; it is currently for specific, specialist mental health services	The information regarding the provider collaborative included is correct. There is no intention to limit the potential scope of the mental health collaborative. Although it's true that SLP has so far focused on joint working on particular more specialist services, it would not be useful to constrain it to this. It may be that the ICS deems it important in future for the collaborative to work together on improving other services. As such the wording has not been changed.
Standing orders 4.5 Nominated Deputies Board Members are expected to attend all Board meetings and as such deputies will not be permitted to attend on their behalf To enable representation of each sector group at every meeting, would suggest having a designated partner member deputy from eligible members within that sector. This means e.g., that if the mental health member cannot attend, there is no voice around the table for mental health. There will inevitably be times when someone is unavoidably detained, unwell etc and ideally each sector should be represented.	Please refer to the answer on deputies and proxy voting. It should also be noted that all Board members represent south east London as a whole and not a particular sector,

Our Healthier South East London
Integrated Care System

NHS

Feedback

What we have heard (main themes)	What we have done in response
Standing Orders 4.7.1 The quorum for meetings of the Board will be at least 50% of voting members, rounded up to the next whole number member and must also include: a) At least 2 executive members b) At least 1 of the independent non executives c) At least 6 of the partner members This means that potentially you could have no clinical member present, or neither the CEO nor CFO. This could perhaps specify e.g. At least 2 Executive members, including the Medical Director or Director of Nursing; CEO or Finance Director.	This has now been changed as suggested.
4.8.1 In the event of a vacancy or defect in appointment the quorum will remain at 50% of total Board members (i.e., no reduction in the quoracy outlined in 4.7.1 of these standing orders). This is presented in black text as if it is prescribed in the model constitution, but it is a local choice. No disagreement with the content, but just to flag that it has not been set down as mandatory!	Thank you for your comment
4.9.2(b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote. This means e.g., that if the mental health member cannot attend, there is no voice around the table for mental health. There will inevitably be times when someone is unavoidably detained, unwell etc and each sector should ideally be represented.	Please see response on deputies. It should also be noted that all Board members represent south east London as a whole and not a particular sector

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NHS

Feedback

What we have heard (main themes)	What we have done in response
"*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*." We recommend reinstating this section from the model constitution	The ICB has not currently agreed a code of conduct & behaviours to include reference in the constitution. A standard of business conducts policy will be in place which all members will be expected to adhere to.
6.3.6 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 We recommend reinstating this section from the model constitution	Thank you for your comment but it is not considered that this needs to be in the constitution.

Our Healthier South East London
Integrated Care System

NHS

Feedback

What we have heard (main themes)	What we have done in response
"*In line with section 14Z52 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:* *a) Add local arrangements*" What is the timeline to agreeing local arrangements?	We are developing a working with people and communities strategy which will inform some of the arrangements the ICB takes forward, but this won't be complete until March. However, narrative has now been included in the constitution.
Section 7.2.8 - We would like clarification on where *the ICB will publish a plan and proposed steps to implement the joint health and wellbeing strategies*. Does this mean that the ICB will publish all of the local strategies (signed off by the Health and Wellbeing Boards)? Or just the ICB role in the plans? The latter looks odd, but the former would cut across local authority accountabilities, as the sponsors of the Health and Wellbeing Boards?	The ICB will publish "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." This will be available on the ICB's website. The ICB will not publish local health and wellbeing strategies but will include in its plan the proposed steps to respond to them.

Our Healthier South East London
Integrated Care System

NHS

Feedback

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The NHS SEL ICB is committed to partnership and empowering people to deliver changes, involving 'our communities as actively as possible in our system' (1.1). However: a) service user or public voices (including those brought by Healthwatch) are not mandatory, and the key section on consultation (9.1.2) and arrangements for public participation is yet to be written. b) It is difficult to understand how the representation of the public or patient voice through the stated membership. c) The constitution should clarify how Board and Committee meetings will involve the public other than through attendance as mentioned in 4.11.1 and 7.2.1. We believe that arrangements for public participation in meetings should include that the public may put questions to the ICB and Committees both ahead of meetings and during its meetings.	a) The draft constitution includes the following: 9.2 In line with section 14Z52 of the 2006 Act the ICB has made arrangements to consult its population on its system plan. 9.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities. 9.5 These arrangements, include: Outreach Working with trusted voices in VCSE and faith organisations Community champions Citizens' Panel Let's talk health and care in south east London engagement platform Working with people with lived experience Co-production b) Work is underway on a Working with People and Communities Strategy for South east London, which Healthwatch are engaged in. This work is currently looking at the most effective way the ICB and wider system can work with the public and local communities and will provide recommendations to the CCG and current ICB leadership in the coming weeks. ICB governance structures are in development and options for a sub-committee/ forum with a focus on public and patient involvement are being reviewed. We would acknowledge, given that thinking is currently at and early stage, that further work on the articulation of this area in the draft constitution is required. c) All public ICB board meetings will include time for attendees to pose questions to board members. When papers are published on the website there will also be advice on how to pose questions in advance of meetings.

Our Healthier South East London
Integrated Care System

NHS

Feedback

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Section 3.14.6 states, *'Subject to satisfactory appraisal, the Chair may approve the re-appointment of an independent non-executive member up to the maximum number of terms permitted for their role'.* This is the only mention of an appraisal process throughout the draft constitution. Firstly, we would suggest the term *satisfactory appraisal* is ambiguous and should be better defined. Secondly, do all members need to be appraised to ensure a fair process for all members?	These are standard words provided by NHS England in the model constitution and are understood to be fixed at this stage. Annually, the chair will agree a set of objectives for each board member. Any re-appointment would therefore be on condition that these objectives had been met or there was sufficient mitigation for why they had not been, as well as the chair confirming that they had continuously demonstrated the skills and behaviours expected for these roles.
The constitution should clarify how Board members are accountable to the Board and how this accountability is enforced.	It is not considered that this should be included within the constitution but should form part of individually set objectives with board members.
Section 3.15.2 states *'With the exception of the Chair, Board members shall be removed from office if any of the following occurs: a) They no longer fulfil the requirements of their role or become ineligible for their role as set out in this constitution, regulations or guidance b) In the opinion of the Chair, they fail to meet satisfactory performance standards*. a) It would be helpful for there to be some indication of what the indicators of not meeting satisfactory performance standards are b) Is there an appeal process or an opportunity for such a Board member to comment on the proposed removal?	This has now been clarified with further detail included to make this clearer referencing this to section 3.1.1. of the constitution which outlines the expectation of members to follow the Nolan principles, comply with fit and proper person expectations, and fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification. Regular non-attendance at meetings has also been included. 3.13.3 states "Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.15.2 apply."