ICB Meeting 1st July. Agenda Item 4.a

Hampshire and Isle of Wight

NHS Hampshire and Isle of Wight Integrated Care Board

CONSTITUTION

Version	Author	Designation	Date	Changes
1.8			1 July 2022	Effective Date

CONTENTS

1. Introduction

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.

1.1.1 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 The Hampshire & Isle of Wight Integrated Care System (ICS) serves a population of 1.9 million people in the local authority areas of Portsmouth, Southampton, county of the Isle of Wight and Hampshire (with the exception of parts of North-East Hampshire, which are served by the Frimley ICS).

1.1.3 There are 158 GP practices, working in 42 primary care networks, and over 900 suppliers of domiciliary, nursing and residential care. There are over 300 community pharmacies, more than 200 providers of dental services providing a range of general dentistry and orthodontics and nearly 200 providers of optometry services.

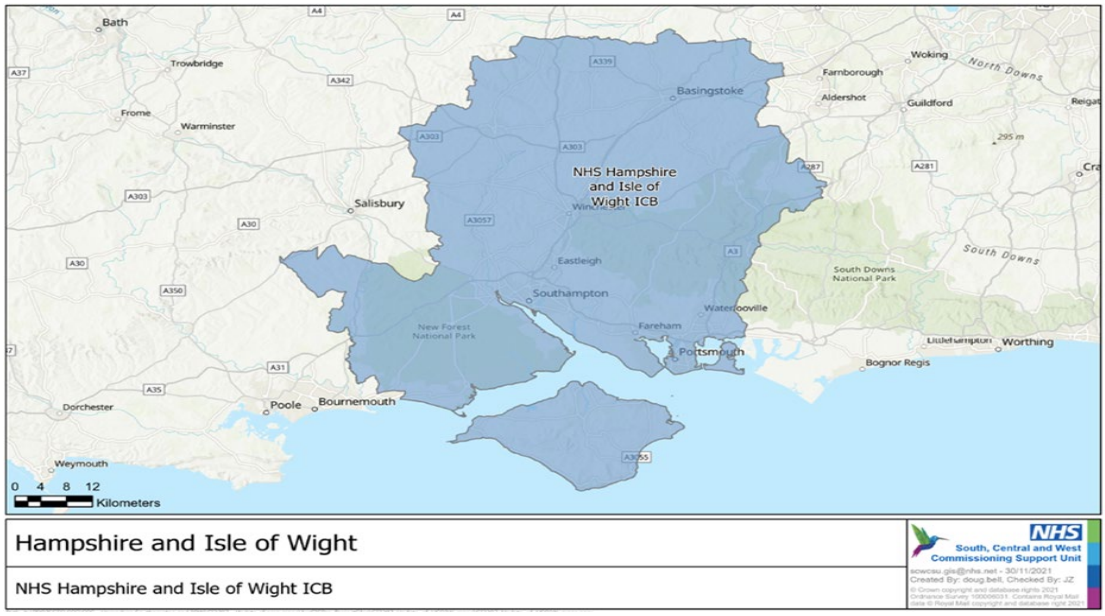
1.2 Name

The name of this Integrated Care System NHS Body is NHS Hampshire and Isle of Wight ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is associated in the local authority areas of:

a) Hampshire (with the exception of the towns of Aldershot and Farnborough, but including the Lower Layer Super Output Area (LSOA) codes in Appendix 3),
b) Southampton,
c) Portsmouth,
d) County of the Isle of Wight.



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 www.hantsiowhealthandcare.org.uk

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

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

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

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under—
a) section 14Z34 (improvement in quality of services)
b) section 14Z35 (reducing inequalities)
c) section 14Z38 (obtaining appropriate advice)
d) section 14Z40 (duty in respect of research)
e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z44 (public involvement and consultation)
g) sections 223GB to 223N (financial duties)
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies)

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

1.5 Status of this Constitution

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

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

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

1.6 Variation of this Constitution

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

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

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

a) Following discussion with board members, the Chair and CEO may periodically propose amendments to the constitution, which shall be considered and approved by the ICB. Such proposed amendments may arise from open and transparent engagement processes with the ICP, board review processes or at the request of the Chair and CEO. All proposed changes will be communicated to the ICP.
b) Proposed amendments to this constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

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

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

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

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

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

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 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 of those organisations in accordance with section 65Z6 of the 2006 Act.
- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
- The up-to-date list of eligible providers of primary medical services under clause 3.6.2

Key policy documents - which should also be included in the Governance Handbook or linked to it, including:

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

2 Composition of the Board of the ICB

2.1 Background

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

2.1.2 Further information about the individuals who fulfil these roles can be found on our website www.hantsiowhealthandcare.org.uk

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

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

2.1.4 The membership of the Integrated Care System NHS Body (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:
- Director of Finance referred to as the Chief Finance Officer
- Medical Director referred to as the Chief Medical Officer
- Director of Nursing referred to as the Chief Nursing Officer

b) At least two independent non-executive members
c) In addition, the ICB has agreed to locally appoint:

- Chief People Officer
- Chief Operating Officer
- Chief Strategy and Transformation Officer

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 are identified and appointed in accordance with the procedures set out in Section 3 below:

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description
- the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description

- the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.

2.1.7 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 a minimum of nine Partner Members.

a) 5 Local Authority
b) 2 NHS Trusts
c) 2 Primary Care Providers

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

a) Three additional Executive Directors
b) Two additional Non-Executive Directors

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 (of which one must bring an acute services perspective and one must bring a community and mental health perspective)
d) 2 Partner member(s) primary care services (of which at least one must primary medical)
e) 5 Partner member(s) Local Authorities (each of which must bring specific perspectives, one local authority leadership, one public health, one adult social care, one children's services and one wider determinants of health from the perspective of a District or Borough Council)
f) 4 Non-Executive members
g) Chief Finance Officer
h) Chief Medical Officer
i) Chief Nursing Officer
j) Chief People Officer
l) Chief Operating Officer
m) Chief Strategy and Transformation Officer

2.2.4 The Chair will exercise their function to approve the appointment of the ordinary members with a view to ensuring diversity of the board and inclusion of a wide range of perspectives and expertise. This will include the appointment of an NHS and Foundation Trust partner member (2.2.3 c) who

has 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.

2.2.6 The board will follow a continuous development programme which will include a full review of the effectiveness of the Board to be undertaken six months after the establishment of the board which will include a review of the board size and composition. In support of this review any posts beyond the minimum required for compliance with national requirements and quoracy which are not filled in the ICB establishment period will be held vacant at the discretion of the Chair until the conclusion of the review of the Board size and composition.

2.3 Regular Participants and Observers at board Meetings

2.3.1 The board may invite specified individuals to be Participants or Observers at its meetings 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.

a) The ICB is not specifying any regular participants

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.

a) The ICB expects the Director of Communications or a suitably skilled and experienced member of their team to observe each meeting of the board to support effective, timely and transparent communication of the work of the board.

2.3.4 Participants and / or observers may be asked to leave the meeting by the Chair if the board passes a resolution to exclude the public as per the Standing Orders.

3 Appointments Process for the Board

3.1 Eligibility Criteria for Board Membership

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test"
b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles)
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification Criteria for Board Membership

3.2.1 The following have been identified as disqualification criteria for Board membership:

3.2.1.1 A person who is a Member of Parliament.

3.2.1.2 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.

3.2.1.3 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.

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

3.2.1.5 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.

3.2.1.6 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.

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

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

3.2.1.8 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).

3.2.1.9 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.

3.2.1.10 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.

3.3.3 Individuals will not be eligible if:

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

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

3.4 Chief Executive

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

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

3.4.3 The Chief Executive must fulfil the following additional eligibility criteria
a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Meet the requirements as set out in the Chief Executive Person Specification.

3.4.4 Individuals will not be eligible if
a) Any of the disqualification criteria set out in 3.2 apply
b) Subject to clause 3.4.3(a), they hold any other employment or executive role

3.5 Partner Member(s) - NHS Trusts and Foundation Trusts

3.5.1 NHS Trusts and/or FTs which provide services for the purpose 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.

- Hampshire Hospitals NHS Foundation Trust
- Isle of Wight NHS Trust
- Portsmouth Hospital University NHS Trust
- Solent NHS Trust
- South Central Ambulance Service NHS Foundation Trust
- Southern Health NHS Foundation Trust
- University Hospital Southampton NHS Foundation Trust

3.5.2 This/ these member(s) 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 NHS Foundation Trusts within the ICB's area,
b) One member must have specific and current knowledge, skills and experience of the provision of acute and/or ambulance services commensurate with the role of Chief Executive Officer and be employed by one of the organisations listed in 3.5.1.
c) One member must have specific and current knowledge, skills and experience of the provision of community and mental health services commensurate with the role of Chief Executive Officer and be employed by one of the organisations listed in 3.5.1.

3.5.3 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply
b) A conflict of interest is evident as described in the ICB Conflicts of Interest Policy or as determined by the Chair or the ICB appointment panel, which results in that individual being unable to fulfil the role.

3.5.4 This/ these member(s) will be appointed by an ICB appointments panel subject to the approval of the Chair.

3.5.5 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 two nominations.
- The nomination of an individual must be seconded by one other eligible organisations.
- Each organisation will determine the manner in which their nomination or seconding is conferred.
- 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 10 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 a consensus is reached on the nominations put forward.

b) **Assessment, selection, and appointment** subject to approval of the Chair under c)

- The full list of nominees will be considered by a panel convened by the Chief Executive
- 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 3.5.2 and 3.5.3
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment taking into consideration both the qualities of the nominees and the diversity and skills of the Board as a whole.

c) Chair's approval

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

- The term of office for Partner Members will be three years, with an initial term of one, two or three years to allow for a cycle of replacement and continuity with subsequent terms of three years. The total number of terms they may serve is three.

3.6 Partner Member(s) - Providers of Primary Care Services.

3.6.1 This/ these Partner Member is/ are jointly nominated by providers of primary medical services for the purposes of the health service within the ICB area and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.

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

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

a) holders of a contract for core primary care services who also holds a list of registered patients are eligible to take part in the nominations process

b) one member must be a current provider of general medical services, working a minimum of two sessions per week in a primary care setting in Hampshire and the county of Isle of Wight

c) one member must be a current provider of primary care services (within primary medical, pharmacy, optometry or dental services being a registered clinician within any of these settings to include nursing and allied health professionals), working a minimum of two sessions per week in a primary care setting in Hampshire and the county of the Isle of Wight

3.6.4 Individuals will not be eligible if:

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

b) Any additional criteria set out in NHSE guidance

c) A conflict of interest is evident, as determined by the ICB policy on conflicts of interest, the Chair or the ICB appointment panel, which results in the individual being unable to fulfil the role.

3.6.5 This member will be appointed by an ICB appointment panel subject to the approval of the Chair

3.6.6 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 two nominations.
- The nomination of an individual must be seconded by one other eligible organisations.
- Each organisation will determine the manner in which their nomination or seconding is conferred.
- 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 10 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 by a panel convened by the Chief Executive

- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.3 and 3.6.4
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment taking into consideration both the qualities of the nominees and the diversity and skills of the Board as a whole.

c) Chair's approval

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

3.6.7 The term of office for Partner Members will be three years, with an initial term of one, two or three years to allow for a cycle of replacement and continuity with subsequent terms of three years. The total number of terms they may serve is three.

3.7 Partner Member(s) - local authorities

3.7.1 These Partner Member(s) are nominated jointly by the local authorities with responsibility for social care whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) Hampshire County Council
b) Southampton City Council
c) Portsmouth City Council
d) Isle of Wight Council

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

a) Each member shall have experience commensurate with the role of Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.7.1. or in the case of the District or Borough perspective partner role, experience commensurate with the role of Chief Executive or hold a relevant Executive level role in a District or Borough Council serving populations within the geographical bounds of the ICB as specified at 1.3.1.

b) Each member shall be employed by one of the organisations listed in 3.7.1 or specific knowledge, skills and experience of District or Borough perspectives, on addressing the wider determinants of health experience commensurate with the role of Chief Executive or hold a relevant Executive level role in a District or Borough Council serving populations within the geographical bounds of the ICB as specified at 1.3.1.

c) In addition to a) and b) one member must have specific and current knowledge, skills and experience of local authority leadership commensurate with the role of Chief Executive Officer or Executive Director.

d) In addition to a) and b) one member must have specific and current knowledge, skills and experience of the provision of adult social care commensurate with the role of Chief Executive Officer or Executive Director.

e) In addition to a) and b) one member must have specific and current knowledge, skills and experience of children's services commensurate with the role of Chief Executive Officer or Executive Director.

f) In addition to a) and b) one member must have specific and current knowledge, skills and experience of the provision of public health, commensurate with the role of Chief Executive Officer or Executive Director.

g) In addition to a) and b) one member must have specific and current knowledge, skills and experience of provision of services to address the wider determinants of health in a District or Borough Council, commensurate with the role of Chief Executive Officer or Executive Director.

3.7.3 Individuals will not be eligible if:

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

b) A conflict of interest is evident, as determined by the ICB policy on conflicts of interest, the Chair or the ICB appointment panel, which results in the individual being unable to fulfil the role.

3.7.4 This member will be appointed by the ICB appointment panel subject to the approval of the Chair.

3.7.5 The appointment process will be as follows

a) Joint Nomination:

- When a vacancy arises, each eligible organisation listed at 3.7.1.a will be invited to make five nominations.
- The nomination of an individual must be seconded by one other eligible organisation.
- Eligible organisations may nominate individuals from their own organisation or another organisation

- Each organisation will determine the manner in which their nomination or seconding is conferred.
- 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 ten 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 a consensus is reached on the nominations put forward until majority acceptance is reached on the nominations put forward

b) Assessment, selection, and appointment subject to approval of the Chair under c)

- The full list of nominees will be considered by a panel convened by the Chief Executive
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.2 and 3.7.3
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment taking into consideration both the qualities of the nominees and the diversity and skills of the Board as a whole.

c) Chair's approval

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

3.7.6 The term of office for Partner Members will be three years, with an initial term of one, two or three years to allow for a cycle of replacement and continuity with subsequent terms of three years. The total number of terms they may serve is three.

3.8 Medical Director

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act,
b) Be a registered Medical Practitioner,
c) Meets the requirements as set out in the Medical Director Person Specification.

3.8.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply,
b) A conflict of interest is evident, as determined by the ICB policy on conflicts of interest, the Chair or the ICB appointment panel, which results in the individual being unable to fulfil the role.

3.8.3 This member will be appointed by the Chief Executive subject to the approval of the Chair and referred to within the ICB as the Chief Medical Officer.

3.9 Director of Nursing

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act,
b) Be a registered Nurse,
c) Meets the requirements as set out in the Director of Nursing Person Specification.

3.9.2 Individuals will not be eligible if:

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

b) A conflict of interest is evident, as determined by the ICB policy on conflicts of interest, the Chair or the ICB appointment panel, which results in the individual being unable to fulfil the role.

3.9.3 This member will be appointed by the Chief Executive subject to the approval of the Chair and referred to within the ICB as the Chief Nursing Officer

3.10 Director of Finance

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act,
b) Be a qualified accountant,
c) Meets the requirements as set out in the Director of Finance person specification.

3.10.2 Individuals will not be eligible if:

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

b) A conflict of interest is evident, as determined by the ICB policy on conflicts of interest, the Chair or the ICB appointment panel, which results in the individual being unable to fulfil the role.

3.10.3 This member will be appointed by the Chief Executive subject to the approval of the Chair and referred to within the ICB as the Chief Finance Officer

3.11 Chief People 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 18(4)(b) of Schedule 1B to the 2006 Act,
b) Be a qualified people professional,
c) Meets the requirements as set out in the Chief People Officer person specification.

3.11.2 Individuals will not be eligible if:

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

b) A conflict of interest is evident, as determined by the ICB policy on conflicts of interest, the Chair or the ICB appointment panel, which results in the individual being unable to fulfil the role.

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

3.12 Chief Operating 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 18(4)(b) of Schedule 1B to the 2006 Act,
c) Meets the requirements as set out in the Chief Operating Officer person specification.

3.12.2 Individuals will not be eligible if:

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

b) A conflict of interest is evident, as determined by the ICB policy on conflicts of interest, the Chair or the ICB appointment panel, which results in the individual being unable to fulfil the role.

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

3.13 Chief Strategy and Transformation 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 18(4)(b) of Schedule 1B to the 2006 Act,
c) Meets the requirements as set out in the Chief Strategy and Transformation Officer person specification.

3.13.2 Individuals will not be eligible if:

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

b) A conflict of interest is evident, as determined by the ICB policy on conflicts of interest, the Chair or the ICB appointment panel, which results in the individual being unable to fulfil the role.

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

3.14 Non-Executive Members

3.14.1 The ICB will appoint four Non-Executive Members.

3.14.2 These members will be appointed by an appointment panel subject to agreement by the Chair

3.14.3 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) One member should have specific knowledge, skills and experience in Quality and Safety to adopt an investigative approach to understanding quality and safety of services.

f) One member should have specific knowledge, skills and experience in Digital and Transformational services

g) One member of the four should have specific knowledge, skills and experience that makes them suitable to take the role of a senior independent member and take a lead role in the appraisal of the chair. This may not be the Chair of the Audit Committee,

h) Meets the requirements of the Non-Executive Director person specification.

3.14.4 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) A conflict of interest is evident, as determined by the ICB policy in respect of managing conflicts of interest, the Chair of the ICB appointment panel my consider the individual unable to fulfil the role.

3.14.5 The term of office for a Non-Executive Member will initially be for one or two years to allow for a cycle of replacement and continuity with subsequent terms of three years. The total number of terms an individual may serve is three, after which they will no longer be eligible for re-appointment.

3.14.6 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

3.14.7 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.

3.15 Other Board Members will be listed here if any are appointed.

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 a minimum of 75% of meetings to which they are invited over a 6-month period unless agreed by the Chair, where there are extenuating circumstances.
c) If they are deemed to not meet the expected standards of performance at their annual appraisal including participation in board and personal development activities including 360 peer feedback.
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICBS (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise.
e) If they are deemed to have failed to uphold the Nolan Principles of Public Life.
f) If they 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 and Non-executive members, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published on the ICB website or in the governance handbook, and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England.

3.17.2 A separate remuneration panel will set remuneration for non-executive members.

3.17.3 The Remuneration Committee will determine other terms of appointment.

3.18 Specific arrangements for appointment of Ordinary Members made at establishment

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

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

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

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

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

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) organisations within the ICB area 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

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

4.3 Authority to Act

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

a) any of its members or employees.

b) a committee or sub-committee of the ICB.

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

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

4.4 Scheme of Reservation and Delegation

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

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

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 setting out at a high level, its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published in the governance handbook on www.hantsiowhealthandcare.org.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.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the board· All terms of reference are published in the governance handbook.

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

a) Provide assurance reports to the ICB

b) Relevant Chair to attend ICB to present reports, as requested

c) Comply with internal audit recommendations

d) Undertake annual committee effectiveness reviews

e) Review annually their terms of reference to ensure they remain relevant

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

4.6.6. All members of committees and sub-committees that exercise the ICB commissioning functions will be appointed by the Chair. The Chair will not appoint an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the

independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise

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

4.6.8 The following committees will be maintained:

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

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

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

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

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

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

4.7 Delegations made under section 65Z5 of the 2006 Act

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

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

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

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

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

5 Procedures for Making Decisions

5.1 Standing Orders

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

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

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

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

5.2 Standing Financial Instructions (SFIs)

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

5.2.2 A copy of the SFIs published on the ICB website at www.hantsiowhealthandcare.org.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 are published on the website.

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

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

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest that could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, must be considered as a potential conflict, and is subject to the provisions of this constitution and the Standard of Business Conduct and Conflicts of interest 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) Requiring staff to comply with this constitution and any guidance published on the website.
b) Requiring staff to proactively declare interests at the point they become involved in decision making
c) Considering a range of actions, which may include:
- deciding that no action is warranted.
- restricting an individual's involvement in discussions and excluding them from decision making.
- removing an individual from the whole decision making process.
- removing an individual's responsibility for an entire area of work.
- removing an individual from their role altogether if the conflict is so significant that they are unable to operate effectively in the role.
- Keeping an audit trail of the actions taken.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

a) Members of the ICB

b) Members of the board's committees and sub-committees

c) Its employees

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

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

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

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

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

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

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

6.4 Standards of Business Conduct

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

- act in good faith and in the interests of the ICB;
- follow the Seven Principles of Public Life, set out by the Committee on Standards in Public Life (the Nolan Principles);
- comply with the ICB Standards of Business Conduct Policy and conflicts of interest 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 outlined in the ICB's Standards of Business Conduct and Conflict of Interests policy.

7. Arrangements for ensuring Accountability and Transparency

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

7.2 Principles

7.2.1 The principle of transparency requires that any information addressed to the public, stakeholders, partners and staff should be concise, easily accessible and easy to understand, and that clear and plain language and, additionally, where appropriate, visualisation be used.

7.2.2 The ICB will provide full and honest accounting of all facts, information, and context essential to ensuring an informed and equitable decision-making process.

7.2.3 The ICB will be open and honest, not conceal unflattering information nor fail to identify conflicts of interest

7.2.4 The ICB will agree a clear set of shared outcomes, which form the basis of robust mutual accountability. Local system plans will set the agenda for conversations about how and where systems will make a difference

7.3 Meetings and publications

7.3.1 Where a publication is referenced within this document, it will be loaded on the ICB websitewww.hantsiowhealthandcare.org.uk

7.3.2 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.

7.3.3 Papers and minutes of all meetings held in public will be published on the ICB website www.hantsiowhealthandcare.org.uk

7.3.4 Annual accounts will be externally audited and published.

7.3.5 A clear complaints process will be published.

7.3.6 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.

7.3.7 Information will be provided to NHS England as required.

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

- Conflicts of interest policy and procedures
- Registers of interests;
- The ICB's policies and procedures;
- ICB Annual Reports and Governance Statements;
- Minutes of meetings of the ICB and ICP held in public;
- Relevant equality and diversity documents and information and comply with the Public Sector Equality Duty;
- Relevant business resilience and emergency planning documents and information;
- Patient information documents, including notices of any public engagement events;
- Other communications issued by the ICB, including the clinical commissioning strategy, the financial plan and notices of procurement, public consultations, reports, ICB and ICP meetings dates, venues and papers;
- Details of the ICB's key strategic priorities and plans;
- Register of Interests; and
- Register of Gifts, Hospitality and Sponsorship.

7.3.9 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), and
- sections 223GBH and 223NJ (financial duties sections 223H and 223J (financial duties).

And

- Proposed steps to implement NHS Hampshire and the county of the Isle of Wight joint local health and wellbeing strategy.

7.4 Scrutiny and Decision Making

7.4.1 At least four 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 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.
- Making arrangements for the delivery of NHS services in a transparent way, in the best interests of patients, taxpayers and the population.
- Publishing intentions for arranging services in advance, publishing contracts awarded and recording decision-making.
- Ensuring there are appropriate governance structures to deal with any challenges that may follow decisions about provider selection.

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

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

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

a) Independent HR advisers will be called upon as required to support the remuneration committee.

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

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

8.1.6 The duties of the Remuneration Committee include:

a) Setting the ICB pay policy and standard terms and conditions
b) Making arrangements to pay employees such remuneration and allowances as it may determine
c) Set remuneration and allowances for members of the board (other than Non-Executives)
d) Setting any allowances for members of committees or 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.

8.1.8 The ICB has established a separate review panel for setting the pay and conditions of Non-Executive Directors as described in the Governance Handbook.

9 Arrangements for Public Involvement

9.1 In line with section 14Z454(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, such as Healthwatch and the independent sector, 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 the development and consideration of proposals by the ICB

b) for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the way the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them, and

c) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

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

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.
b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.
c) Understand the 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 Local arrangements, include:

a) Primary Care Network / Neighbourhood Groups

- To support Primary Care Networks to engage and involve local communities in the development of health and care services for their local area including proposed service changes and transformation projects. Groups will cover all aspects of health and social care including primary, secondary and urgent care, mental health and community and social care. PPG rep from each practice

b) **Place Community Engagement Groups**

- To support the ICB / ICS to engage and involve local communities in the development of health and care services for that area including proposed service changes and transformation projects. Groups will cover all aspects of health and social care including primary, secondary and urgent care, mental health and community and social care

c) **HIOW Wide Group**

- Support the collaboration between HIOW ICS, Clinical Networks, other partners as agreed, and Healthwatch based in Hampshire, Southampton, Portsmouth and the county of the Isle of Wight, to ensure high quality community involvement across the ICS. Also to provide informal consultancy, advice and guidance for community involvement initiatives across all ICS levels

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.
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 Member	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are appointed in accordance with the procedures set out in section 3, having been nominated by the following: a) NHS Trusts and Foundation Trusts who provide services within the ICB's area and are of a prescribed description b) The Primary Medical Services (general practice) providers within an area of the ICB and are of a prescribed description. c) 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.

Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
Chief Medical Officer	The local term for the ICB Medical Director
Chief Nursing Officer	The local term for the ICB Director of Nursing
Chief Finance Officer	The local term for the ICB Director of Finance

Appendix 2: Standing Orders

1. Introduction

1.1. These Standing Orders have been drawn up to regulate the proceedings of NHS Hampshire and Isle of Wight 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 1st July 2022.

2.2. Subject to NHSE setting an approval date, 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 paragraph 1.6.

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 Board Secretary 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 urgent situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

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

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

4.2. Chair of a meeting

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

4.2.2. If the Chair is absent or is disqualified from participating by a conflict of interest, the deputy Chair (if one is appointed) shall preside. If no

deputy is present, with agreement of the assembled members of the board, a Chair will be nominated.

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

4.3. Agenda, supporting papers and business to be transacted

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

4.3.2. Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven working days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the board at least five working 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 www.hantsiowhealthandcare.org.uk at least three working days before the meeting.

4.4. Petitions

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

4.5. Nominated Deputies

4.5.1. With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the board may nominate a deputy to attend a meeting of the board that they are unable to attend. The deputy may speak and vote on their behalf.

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

4.6. Virtual attendance at meetings

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

4.7. Quorum

4.7.1. The quorum for meetings of the board will be 12 members, including:

a) The Chair or nominated deputy
b) Either the Chief Executive or the Director of Finance
c) Either the Medical Director or the Director of Nursing
d) One member with a clinical perspective (drawn from the partner members for public health and primary care).
e) Two independent non-executive director members
f) Two partner members from a local authority (drawn from the partner members for local authority leadership, adult social care, children's services and wider determinants of health)
g) One partner member from an NHS Trust or NHS Foundation Trust

4.7.2. For the sake of clarity:

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

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

4.8. Vacancies and defects in appointments

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

4.8.2. In the event of or defect in appointment, the members of the ICB will decide if changes are required to quoracy

4.9. Decision making

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

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

a) All members of the board who are present at the meeting will be eligible to cast one vote each.
b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
c) For the sake of clarity, any additional Participants and Observers (as detailed within paragraph 5.6. of the constitution) will not have voting rights.
d) A resolution will be passed if more votes are cast for the resolution than against it.
e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Emergency decisions

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

4.9.4. The powers which are reserved or delegated to the board, may for an emergency 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 as many members as possible in the given circumstances.

4.9.5. 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 due to 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 seal is only affixed to documents where the sealing has been authorised by a resolution of the board or of a Committee of the board, or where the board has delegated its powers. The ICB will use a seal for executing documents where necessary. Every quarter the Board Secretary will present a report to the board that records all documents sealed in that period (if applicable).

6.1.1 The following individuals or officers are authorised to authenticate its use and are authorised to execute a document on behalf of the ICB by their signature:

a) The Chief Executive
b) The Chair of the ICB (The Independent Chair)
c) The Chief Medical Officer /Chief Nursing Officer
d) The Chief Finance Officer

Appendix 3

List of Post codes not included in the Place area of Hampshire as they are dealt with by Frimley ICS (www.frimleyhealthandcare.org.uk).

ONS Unique ID, LSOA Code

E01023099	Rushmoor 001A	1,568	E54000034	QNQ	NHS Frimley ICB
E01023104	Rushmoor 001B	1,604	E54000034	QNQ	NHS Frimley ICB
E01023106	Rushmoor 001C	1,416	E54000034	QNQ	NHS Frimley ICB
E01023121	Rushmoor 001D	1,931	E54000034	QNQ	NHS Frimley ICB
E01023105	Rushmoor 002A	1,543	E54000034	QNQ	NHS Frimley ICB
E01023119	Rushmoor 002B	1,248	E54000034	QNQ	NHS Frimley ICB
E01023120	Rushmoor 002C	1,677	E54000034	QNQ	NHS Frimley ICB
E01023122	Rushmoor 002D	1,440	E54000034	QNQ	NHS Frimley ICB
E01023146	Rushmoor 002E	1,338	E54000034	QNQ	NHS Frimley ICB
E01023100	Rushmoor 003A	1,113	E54000034	QNQ	NHS Frimley ICB
E01023101	Rushmoor 003B	1,227	E54000034	QNQ	NHS Frimley ICB
E01023102	Rushmoor 003C	1,347	E54000034	QNQ	NHS Frimley ICB
E01023134	Rushmoor 003D	1,699	E54000034	QNQ	NHS Frimley ICB
E01023147	Rushmoor 003E	1,438	E54000034	QNQ	NHS Frimley ICB

E01023096	Rushmoor 004A	2,204	E54000034	QNQ	NHS Frimley ICB
E01023097	Rushmoor 004B	1,424	E54000034	QNQ	NHS Frimley ICB
E01023103	Rushmoor 004C	1,455	E54000034	QNQ	NHS Frimley ICB
E01023111	Rushmoor 004D	1,775	E54000034	QNQ	NHS Frimley ICB
E01023112	Rushmoor 004E	1,274	E54000034	QNQ	NHS Frimley ICB
E01023092	Rushmoor 005A	1,335	E54000034	QNQ	NHS Frimley ICB
E01023093	Rushmoor 005B	1,314	E54000034	QNQ	NHS Frimley ICB
E01023132	Rushmoor 005C	1,438	E54000034	QNQ	NHS Frimley ICB
E01023133	Rushmoor 005D	1,356	E54000034	QNQ	NHS Frimley ICB
E01023135	Rushmoor 005E	2,394	E54000034	QNQ	NHS Frimley ICB
E01023091	Rushmoor 006A	1,732	E54000034	QNQ	NHS Frimley ICB
E01023094	Rushmoor 006B	1,302	E54000034	QNQ	NHS Frimley ICB
E01023095	Rushmoor 006C	1,778	E54000034	QNQ	NHS Frimley ICB
E01023098	Rushmoor 006D	1,649	E54000034	QNQ	NHS Frimley ICB
E01023148	Rushmoor 006E	1,305	E54000034	QNQ	NHS Frimley ICB
E01023149	Rushmoor 006F	1,280	E54000034	QNQ	NHS Frimley ICB
E01023113	Rushmoor 007A	1,746	E54000034	QNQ	NHS Frimley ICB

E01023114	Rushmoor 007B	1,420	E54000034	QNQ	NHS Frimley ICB
E01023136	Rushmoor 007C	2,508	E54000034	QNQ	NHS Frimley ICB
E01023137	Rushmoor 007D	1,366	E54000034	QNQ	NHS Frimley ICB
E01023138	Rushmoor 007E	1,414	E54000034	QNQ	NHS Frimley ICB
E01023139	Rushmoor 007F	1,215	E54000034	QNQ	NHS Frimley ICB
E01023140	Rushmoor 007G	1,631	E54000034	QNQ	NHS Frimley ICB
E01023141	Rushmoor 008A	2,860	E54000034	QNQ	NHS Frimley ICB
E01023142	Rushmoor 008B	2,902	E54000034	QNQ	NHS Frimley ICB
E01023143	Rushmoor 008C	2,508	E54000034	QNQ	NHS Frimley ICB
E01023144	Rushmoor 008D	1,681	E54000034	QNQ	NHS Frimley ICB
E01023118	Rushmoor 009A	1,796	E54000034	QNQ	NHS Frimley ICB
E01023124	Rushmoor 009B	1,303	E54000034	QNQ	NHS Frimley ICB
E01023125	Rushmoor 009C	2,317	E54000034	QNQ	NHS Frimley ICB
E01032858	Rushmoor 009F	2,147	E54000034	QNQ	NHS Frimley ICB
E01023128	Rushmoor 010A	1,306	E54000034	QNQ	NHS Frimley ICB
E01023129	Rushmoor 010B	1,302	E54000034	QNQ	NHS Frimley ICB
E01023130	Rushmoor 010C	1,286	E54000034	QNQ	NHS Frimley ICB

E01023131	Rushmoor 010D	1,389	E54000034	QNQ	NHS Frimley ICB
E01023145	Rushmoor 010E	2,297	E54000034	QNQ	NHS Frimley ICB
E01023109	Rushmoor 011A	1,490	E54000034	QNQ	NHS Frimley ICB
E01023115	Rushmoor 011B	1,314	E54000034	QNQ	NHS Frimley ICB
E01023116	Rushmoor 011C	1,863	E54000034	QNQ	NHS Frimley ICB
E01023117	Rushmoor 011D	1,740	E54000034	QNQ	NHS Frimley ICB
E01023107	Rushmoor 012A	1,379	E54000034	QNQ	NHS Frimley ICB
E01023108	Rushmoor 012B	1,364	E54000034	QNQ	NHS Frimley ICB
E01023110	Rushmoor 012C	1,723	E54000034	QNQ	NHS Frimley ICB
E01023123	Rushmoor 012D	1,516	E54000034	QNQ	NHS Frimley ICB

The towns of Fleet and Yateley including the LSOA codes of

ONS Unique ID/LSOA Code

E01022890	Hart 001A	1,392	E54000034	QNQ	NHS Frimley ICB
E01022891	Hart 001B	1,780	E54000034	QNQ	NHS Frimley ICB
E01022892	Hart 001C	1,833	E54000034	QNQ	NHS Frimley ICB
E01022893	Hart 001D	1,663	E54000034	QNQ	NHS Frimley ICB
E01022894	Hart 001E	1,439	E54000034	QNQ	NHS Frimley ICB

E01022859	Hart 002A	1,731	E54000034	QNQ	NHS Frimley ICB
E01022895	Hart 002B	1,669	E54000034	QNQ	NHS Frimley ICB
E01022896	Hart 002C	1,503	E54000034	QNQ	NHS Frimley ICB
E01022897	Hart 002D	1,621	E54000034	QNQ	NHS Frimley ICB
E01022898	Hart 002E	1,528	E54000034	QNQ	NHS Frimley ICB
E01022846	Hart 003A	1,732	E54000034	QNQ	NHS Frimley ICB
E01022847	Hart 003B	1,757	E54000034	QNQ	NHS Frimley ICB
E01022848	Hart 003C	1,558	E54000034	QNQ	NHS Frimley ICB
E01022874	Hart 003D	1,333	E54000034	QNQ	NHS Frimley ICB
E01022875	Hart 003E	1,478	E54000034	QNQ	NHS Frimley ICB
E01022876	Hart 003F	1,499	E54000034	QNQ	NHS Frimley ICB
E01022877	Hart 003G	1,424	E54000034	QNQ	NHS Frimley ICB
E01022860	Hart 005A	2,003	E54000034	QNQ	NHS Frimley ICB
E01022862	Hart 005B	2,267	E54000034	QNQ	NHS Frimley ICB
E01022867	Hart 005D	1,482	E54000034	QNQ	NHS Frimley ICB
E01032852	Hart 005E	1,830	E54000034	QNQ	NHS Frimley ICB
E01032853	Hart 005F	1,937	E54000034	QNQ	NHS Frimley ICB

E01032854	Hart 005G	1,820	E54000034	QNQ	NHS Frimley ICB
E01032857	Hart 005H	965	E54000034	QNQ	NHS Frimley ICB
E01022861	Hart 007A	1,632	E54000034	QNQ	NHS Frimley ICB
E01022863	Hart 007B	1,546	E54000034	QNQ	NHS Frimley ICB
E01022865	Hart 007C	1,611	E54000034	QNQ	NHS Frimley ICB
E01022868	Hart 007D	1,633	E54000034	QNQ	NHS Frimley ICB
E01022870	Hart 007E	1,469	E54000034	QNQ	NHS Frimley ICB
E01022864	Hart 008A	1,428	E54000034	QNQ	NHS Frimley ICB
E01022871	Hart 008B	1,414	E54000034	QNQ	NHS Frimley ICB
E01022872	Hart 008C	1,801	E54000034	QNQ	NHS Frimley ICB
E01022873	Hart 008D	2,878	E54000034	QNQ	NHS Frimley ICB
E01022850	Hart 009A	1,763	E54000034	QNQ	NHS Frimley ICB
E01022851	Hart 009B	1,643	E54000034	QNQ	NHS Frimley ICB
E01022853	Hart 009C	1,665	E54000034	QNQ	NHS Frimley ICB
E01022869	Hart 009D	1,872	E54000034	QNQ	NHS Frimley ICB
E01022852	Hart 009E	1,517	E54000034	QNQ	NHS Frimley ICB
E01022853	Hart 010A	1,718	E54000034	QNQ	NHS Frimley ICB

E01022854	Hart 010B	1,706	E54000034	QNQ	NHS Frimley ICB
E01022855	Hart 010C	1,220	E54000034	QNQ	NHS Frimley ICB
E01022856	Hart 010D	1,640	E54000034	QNQ	NHS Frimley ICB
E01022857	Hart 010E	3,806	E54000034	QNQ	NHS Frimley ICB