



DRAFT

# West Yorkshire Integrated Care Board constitution report on responses to involvement



March 2022

# Draft West Yorkshire Integrated Care Board constitution report on responses to involvement

## Introduction

1. From 1 July 2022, subject to legislation, integrated care boards (ICBs) will take on the commissioning responsibilities of clinical commissioning groups (CCGs) and lead the integration of health and care services across their area. This report presents the findings of stakeholder involvement on the draft constitution of the West Yorkshire Integrated Care Board (ICB).
2. The Health and Social Care Bill requires the relevant CCGs to propose the constitution of the first ICB to be established for that area. Before making a proposal, the relevant CCGs were required to involve anyone they considered it appropriate to engage. Although formal consultation on the draft constitution was not required, the CCGs in Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield agreed to undertake a joint stakeholder involvement exercise at both Partnership and local level. To enable all stakeholders and interested parties to contribute, a comprehensive constitution involvement and communication toolkit was produced.

## Approach to involvement

3. On 8 November 2021, we published our [draft constitution](#) on our website, alongside supporting communications including background information, easy read, audio and British Sign Language versions. The involvement period closed on 14 January 2022. Comments were invited on the content of the draft constitution and several supporting documents. We asked for feedback on:
  - the composition of the Board of the ICB.
  - the appointments process for members of the Board of the ICB.
  - the delegation of functions to place-based committees of the ICB
  - the way the ICB proposes to deal with conflicts of interest.
  - the ICB's principles for ensuring accountability and transparency.
  - how the ICB will comply with the requirements of the NHS Provider Selection Regime (subject to regulations).
  - the way the ICB intends to involve the public, patients, carers and stakeholders.
4. In addition to publishing the draft constitution on the Partnership website, we also presented the proposals to a range of forums including:
  - patient and public reference groups;
  - Health and Wellbeing Boards;
  - West Yorkshire and place Health Overview and Scrutiny Committees;
  - partner organisation boards and governing bodies; and
  - partnership forums including the Partnership Board, System Leadership Executive, Chairs and Leaders Reference Group, Clinical Forum and Communication and Engagement Network.

## Responses to the engagement

5. Involvement on the constitution produced responses from partners, external stakeholders and members of the public (see enclosed list). The feedback has been very helpful and constructive and has covered a wide range of areas. The issues receiving most responses were:
  - the size and composition of the ICB Board;
  - the arrangements for delegating the ICBs functions to our places; and
  - public and patient involvement in our ICS.
  
6. A summary of the key issues raised during the involvement period is attached at Annex 2, together with our response and how we propose to amend the draft constitution. The main changes that we have made in response to comments include:
  - clarifying the objectives of the ICB in relation to promoting a comprehensive health service for all its residents, reducing health inequalities and improving wellbeing;
  - strengthening independent challenge and scrutiny by including an additional independent non-executive member of the board with a specific focus on citizen involvement and sustainability;
  - strengthening our focus on people and workforce issues by adding an ICB Director of People to the Board and establishing an ICB People Committee;
  - confirming that all members of the board are full members of a unitary board, responsible for stewardship of NHS funds and bound by individual and collective accountability for decisions;
  - enabling a broader range of representation on the board from providers of community health services and the voluntary, community and social enterprise sector; and
  - building into our arrangements an annual review of Board effectiveness.
  
7. Several other important comments were received, which we will reflect in the governance handbook. The handbook will underpin the constitution and our wider partnership arrangements. In response to comments, we will:
  - set out the key role of Health and Wellbeing Boards in setting strategy;
  - illustrate via case studies the role of provider collaboratives in decision making and partnership working at place and system level;
  - develop case studies to illustrate the potential mechanisms for decision taking across place and ICS footprints;
  - set out clearly in the scheme of reservation and delegation the principles for determining the decisions that will be made at West Yorkshire rather than place level; and
  - review our arrangements for involving citizens - this will include developing a wider citizen panel as recommended in the [independent public involvement review](#) (July 2021) - this will support the work of the ICB and existing involvement methods in place and at a West Yorkshire level and will be coordinated by Healthwatch.

## Summary

8. Stakeholder involvement on the draft ICB constitution has proved very valuable in refining key aspects of the constitution and our supporting governance and citizen involvement arrangements.

### Responses were received from:

- 10 members of the public
- Airedale NHS Foundation Trust
- BMA Yorkshire Regional Council
- Calderdale and Kirklees 999 Call for the NHS
- Community Pharmacy West Yorkshire
- Kirklees Council
- Kirklees Health Overview and Scrutiny Committee
- Leeds Adults, Health and Active Lifestyles Scrutiny Board
- Leeds CCG
- Leeds CCG PPG Network Group
- Leeds Community Healthcare NHS Trust
- Leeds Keep Our NHS Public
- Leeds Local Medical Committee
- Leeds and York Partnership NHS Foundation Trust
- Locala Community Partnerships
- Mid Yorkshire Hospitals NHS Trust
- Nova Wakefield District Limited
- South West Yorkshire Partnership NHS Foundation Trust
- Wakefield Patient and Community Panel,
- West Yorkshire Joint Health Overview and Scrutiny Committee
- Yorkshire Ambulance Service NHS Trust

Involvement on West Yorkshire Integrated Care Board draft constitution – summary of feedback and proposed responses 21.02.22

Feedback on draft constitution	Response/proposed amendment to constitution/governance arrangements
<p><b>Section 1 – Introduction</b></p> <p><b>Objectives and priorities</b></p> <ul style="list-style-type: none"> <li>• Promotion of comprehensive health service should be explicit in the objectives. Important to specify the population covered by ICB – ensure no gaps in provision.</li> <li>• The people and workforce agenda needs more emphasis.</li> <li>• Welcome focus on wider determinants of health, outcomes rather than activity. Focus more on wellbeing than ‘health’, because this better describes overall health. Support focus on prevention, partnership and health inequalities. Need to recognise poverty as a determinant of health.</li> </ul> <p><b>How we work together</b></p> <ul style="list-style-type: none"> <li>• Need to set out role of Health and Wellbeing Boards more clearly.</li> <li>• Embed clinical and professional leadership throughout ICS structures</li> </ul>	<ul style="list-style-type: none"> <li>• Reflect comprehensive health service and resident population in updated draft. <b>(Clause 1.1.2)</b></li> <li>• Importance of people/workforce agenda recognised by proposed establishment of ICB People Committee, Director of People on ICB Board, Independent Non-Executive Member with responsibility for workforce.</li> <li>• Additional references to priority outcomes and poverty as a determinant of health <b>(1.1.16)</b>.</li> <li>• Key role of Health and Wellbeing Boards in setting strategy highlighted <b>(1.1.4)</b> also set out in functions and decisions map. Place ICB Committees will agree a plan to deliver the Health and Wellbeing Strategy. This will also be covered in the governance handbook.</li> <li>• ICB Board will be just one part of a complex and inclusive decision-making framework, which embeds clinical and professional leadership across our system and at board level. At the centre is</li> </ul>

<ul style="list-style-type: none"> <li>• Language important: ‘Local Care Partnerships’ rather than PCNs.</li> <li>• Recognise and support contribution of voluntary community and social enterprise sector (VCSE)</li> <li>• Greater emphasis needed on keeping people well in their own homes through collaborative working</li> <li>• Recognise role of partners including community interest companies, hospices, and independent social care providers.</li> <li>• Collaborative behaviours and relationships are as important as formal governance structures at both place and WY level. Wherever possible, we should streamline formal governance and avoid layers of bureaucracy and duplication.</li> <li>• How is the primacy of strategies determined i.e. each provider’s strategy, that of the place partnerships and the and the ICB, and how do we agree these?</li> <li>• Important that all ICB partners and stakeholders are treated equally and fairly because the outcomes for the communities that the ICB serves are more important than the organisational form of the bodies who deliver those improved outcomes.</li> </ul>	<p>the Clinical Forum, which will remain as the primary forum for clinical leadership, advice, and challenge of the work of the Partnership.</p> <ul style="list-style-type: none"> <li>• Terminology changed <b>(1.1.14)</b>.</li> <li>• VCSE is represented on ICP, ICB Board, Place Committees and in wider partnership structures.</li> <li>• Additional text added <b>(1.1.18)</b>.</li> <li>• Additional text added <b>(1.1.8)</b></li> <li>• We recognise the importance of collaborative relationships. Formal decision-making mechanisms will continue to be underpinned by the work of collaborative forums and networks.</li> <li>• Willingness to collaborate will remain key in ensuring that strategies are complementary across organisations, places, and West Yorkshire.</li> <li>• New text added <b>(1.1.21)</b></li> </ul>
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## Section 2 - The ICB Board – compositionRoles

- There needs to be greater clarity on how the Board will work and how it will make decisions, not just its composition. There needs to be clarity on the roles of those who sit round the table
- The Constitution should clarify how the IC Board Chair and Chief executive can be removed from office and on what grounds.
- The Constitution should clarify if partner members are ordinary members or exec members, and what the difference is between ordinary and exec members. Are all Board members jointly accountable?

### Terms of office for partner members

- Partner members – proposed three x three year terms may preclude CE from continuing as a member when still being accountable in a provider trust.
- Could consider re-nomination by Provider trusts at regular intervals or rotational representation from trusts

### Composition

- Concern that board too big for effective decision-making.

- All Board members have a vote and share accountability for ICB decisions. The constitution states explicitly in para 2.4 that the partner board member role is to bring the perspective of sector/place, not to act as a representative or delegate of the sector or organisation.
- The arrangements are set out in **3.20**.
- New text added to confirm that partner members are full members of a unitary board, responsible for stewardship of NHS funds and are bound by individual and collective accountability for decisions.

- The Board trust partner member role is to bring the perspective of the sector, not to act as a representative or delegate of the sector. Limiting the terms served will help to promote diversity and inclusivity.
- Rotational representation is not possible under expected statutory regulations.

- We have sought to balance inclusiveness and effectiveness. Annual review of board size and effectiveness built into constitution. **(3.23)**  
**(4.1.3)**

<ul style="list-style-type: none"> <li>• Additional frontline clinical representation needed - primary care, secondary care, public health doctors</li> <li>• The board should include the public, 1 councillor from each local authority, Trade Union representatives, 1 Social Care representative and 1 each from dentistry and NHS maternity services.</li> <li>• Important that there is independent public health specialist on ICB and the Partnership Board , to provide expertise on public health rather than to represent a specific organisation.</li> <li>• Should not have private providers on Partnership board or ICB board.</li> <li>• Patients/public/citizen voice. At least 2 patient representatives are needed on the ICB Board to ensure that patient voice is heard</li> <li>• Yorkshire Ambulance Service should be represented in view of importance of ambulance service to broad range of Partnership priorities.</li> </ul>	<ul style="list-style-type: none"> <li>• The board includes Medical Director, Director of Nursing, primary care member and Director of Public health. Clinical subject matter experts will also be invited to attend as required. There is also a Non-Executive Independent Member for Quality and there will be a Quality Committee.</li> <li>• We have sought to balance inclusiveness and effectiveness on our board and members will bring the perspective from citizens and a wide range of sectors. The board will be just one part of a complex and inclusive ICS decision-making framework which enables the involvement of very wide range of stakeholders.</li> <li>• The role of the Director of Public Health board member will be to bring the perspective of Directors of Public Health, not represent a specific organisation.</li> <li>• Private providers are not included on our ICB Board. There are no private providers on our existing Partnership Board, although we propose to broaden its membership to include a representative of independent providers of social care. All board members must declare any conflicts of interest.</li> <li>• ICB Board has an independent Chair and four non-executive independent members – one of whom has a specific remit around citizen voice. In addition, there will also be a Healthwatch Board member. Meetings will be held in public, and the public will be encouraged to ask questions on agenda items. All questions and answers will be publicly available.</li> <li>• Yorkshire Ambulance Service NHS Trust (YAS) are embedded in our Partnership leadership structures and we will invite them to Board meetings for matters on which they have an interest. We will keep</li> </ul>
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<ul style="list-style-type: none"> <li>• Insufficient social care representation on the Board</li> <li>• Representative of community services providers on the board should not be restricted to NHS trusts.</li> <li>• Local authority elected members should be able to sit on ICB Board.</li> <li>• There is a need to ensure that the Board is representative of the breadth of service provision, particularly mental health and learning disability</li> <li>• Requiring provider partner members to be at CEO level within partner organisations this could, by default, introduce a gender and ethnicity bias.</li> <li>• Provider collaboratives are not represented on the Board.</li> <li>• Community pharmacy should be represented on the Board and across the Partnership.</li> </ul>	<p>under review over time. YAS will also have a key role in Yorkshire and Humber inter-ICS governance arrangements.</p> <ul style="list-style-type: none"> <li>• The local authority member and place leads with local authority responsibilities will bring the perspective of social care.</li> <li>• Eligibility criteria will be amended so that the member bringing the perspective of providers of community services is no longer restricted to NHS trusts.</li> <li>• Under national guidance, elected members were that not eligible to be members of the ICB Board. <b>(Note: the Bill has subsequently been amended. Elected members are no longer ineligible, although guidance sets out that it is expected that the member ‘will normally be a senior local authority executive’.</b></li> <li>• The Board includes a partner provider member who will bring the perspective of mental health, learning disability and autism.</li> <li>• The Bill requires that trust partner members must be at executive director level.</li> <li>• Trust partner members of the Board will bring the perspective of their sector, including that of provider collaboratives.</li> <li>• Community pharmacy is represented on the Clinical Forum. We will invite them to Board meetings for matters on which they have an interest. We will keep under review over time.</li> </ul>
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<ul style="list-style-type: none"> <li>• Places are not adequately represented on the Board.</li> <li>• The list of members states “Director of Nursing”, however, this should be broader than just nursing and should be representative of other professional groups including Allied Health Professions.</li> <li>• Suggest non-eligibility for independent members should include roles within CQC, Healthwatch, NHSE or DHSC.</li> <li>• Important not to exclude groups representing other protected characteristics from being in attendance at ICB Board. Inclusivity should be the golden thread through every level of governance of the ICS.</li> </ul>	<ul style="list-style-type: none"> <li>• Each of our five places will have one member on the ICB Board. In addition, each of the sector representatives (for example NHS trusts and local authorities) will also bring insight from their local places too.</li> <li>• The director of nursing role is prescribed in the Bill.</li> <li>• These organisations are covered by the requirement not to hold a role in health or care in the ICS area.</li> <li>• We are reviewing our proposals for groups ‘in attendance’ at Board meetings.</li> </ul>
<p><b>Section 3 - Appointment process for the ICB Board</b></p> <ul style="list-style-type: none"> <li>• What processes will the ICS be using to appoint the statutory roles on its ICB – particularly its GP and medical director members?</li> <li>• Role of the ICB Chair in approving Board members.</li> <li>• VCSE: eligibility criteria too restrictive and should not exclude a person from an infrastructure organisation. Sector should lead the process. Specifying a "senior leader" may exclude representatives from some groups – especially those affected by inequalities. Need</li> </ul>	<ul style="list-style-type: none"> <li>• There has been open, transparent and robust recruitment for all statutory executive board roles. National guidance is yet to be issued on the nomination and appointment process for the primary care member.</li> <li>• It is a national requirement that all Board appointments are approved by the ICB Chair.</li> <li>• Amend eligibility criteria to include VCSE infrastructure organisations (<b>3.15.2</b>). Nomination process will be led by the sector. VCSE member must be able to bring the perspective of the whole VCSE sector and have experience in strategic decision making at a</li> </ul>

<p>backfill payments for the voluntary sector as this work is not funded.</p> <ul style="list-style-type: none"> <li>• There needs to be greater clarity on the process, in particular what safeguards there are to make this as inclusive as possible.</li> </ul>	<p>senior level. Agree that VCSE representatives should not be deterred from taking on roles within the ICB at West Yorkshire or place level because of funding issues. We are working to develop appropriate arrangements.</p> <ul style="list-style-type: none"> <li>• All nomination and appointment processes include a requirement to have regard to the Partnership’s commitment to improving the diversity of its leadership and to ensuring a spread of representation across our places.</li> </ul>
<p><b>Section 4 - Arrangements for the Exercise of our Functions</b></p> <ul style="list-style-type: none"> <li>• Governance handbook is key document – must be made available for scrutiny and comment.</li> <li>• Subsidiarity and place-based decision making must be emphasised. Important to set out what decisions are made at ICS and at Place level. There needs to be recognition in the Scheme of Delegation that the ICB decision making is driven by bottom-up recommendations and what is happening at Place</li> <li>• There needs to be clarity on how we avoid duplication of effort between ICB and Place. For example, what is the distinctive role of the ICB and how will it add value to the decision-making process.</li> <li>• Need flexibility to address issues/make decisions across 2 or more places, not just system e.g. hospital reconfigurations.</li> </ul>	<ul style="list-style-type: none"> <li>• The governance handbook is currently being developed and will be published on our website. It will include the scheme of reservation and delegation, committee structure, terms of reference, key governance policies and decision-making case studies.</li> <li>• The draft constitution and functions and decisions map are based on principles of subsidiarity, with decisions being taken as close as possible to local communities. Place-based ICB committees will play a key role in this.</li> <li>• Distinctive role of the ICB is defined by the 3 tests <b>(1.1.5)</b>. This will also be set out in the scheme of reservation and delegation and governance handbook.</li> <li>• The constitution includes the flexibility for committees, including place committees to establish governance mechanisms to address specific needs <b>(4.6.1)</b>. We will illustrate potential options through case studies/examples in the governance handbook.</li> </ul>

<ul style="list-style-type: none"> <li>• Need to set out arrangements for decisions on services covering more than 1 ICS.</li> <li>• Arrangements are complex and hard to understand. There needs to be greater clarity on how collaborative governance arrangements will operate, setting out how functions will not only be delegated, but how matters can be escalated up through the various ICB / Place governance structures.</li> <li>• The Governance Handbook should specify that there must be no delegation of the Integrated Care Board's powers and functions.</li> <li>• Across the Constitution there needs to be greater clarity on the duty to collaborate alongside the over-riding duty of governance at an organisational level and how this fits with the individual governance arrangements.</li> <li>• In the governance structure diagram there is no reference to NHS Trusts or FT Boards as being statutory organisations involved in the decision-making process.</li> <li>• The role of provider collaboratives is not given sufficient coverage in the constitution.</li> <li>• Add reference to remind the ICB committees that they must have full regard to the values in 1.1.20.</li> </ul>	<ul style="list-style-type: none"> <li>• We are developing case studies for inclusion in the governance handbook.</li> <li>• We will seek to clarify the arrangements in the functions and decisions map, governance structure diagram and the Scheme of reservation and delegation.</li> <li>• All proposed delegation is to committees of the ICB or ICB board member and employees.</li> <li>• Section 1 of the constitution sets out the role of trusts as partners and at <b>1.1.12</b> and <b>1.1.13</b> the relationship with the ICB constitution</li> <li>• The diagram is intended to focus on ICB decisions and functions rather than those of individual statutory organisations. We will amend the diagram to include governance arrangements in trusts and other statutory organisations.</li> <li>• In line with our principles of subsidiarity, the model of delegation set out in the constitution and scheme of reservation and delegation is to place. Provider collaboratives will continue to play a key role within this model at both place and system level. We will develop case studies to illustrate the role of provider collaboratives. These case studies will be included in our governance handbook.</li> <li>• Text added at <b>(4.6.4)</b>.</li> </ul>
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<p><b>Section 6 - Conflict of Interests and Standards of Business Conduct</b></p> <ul style="list-style-type: none"> <li>Conflicts must be managed carefully, particularly in relation to the role of provider members of the Board and committees.</li> </ul>	<ul style="list-style-type: none"> <li>ICB will have a conflicts of interest policy which will be applied to all ICB decision taking. This will cover the role of provider members. Further guidance on managing conflicts of interest is expected from NHS England.</li> </ul>
<p><b>Section 7 - Accountability and Transparency</b></p> <ul style="list-style-type: none"> <li>What are the arrangements for having lay members on ICB/ICP decision making bodies.</li> <li>Need for greater clarity on compliance with the provider selection regime including the relative importance of all material selection criteria.</li> <li>Detail is needed on compliance with Freedom of Information regulations and Data Protection regulations</li> <li>Specify that compliance with local authority health overview and scrutiny requirements includes joint health overview and scrutiny requirements.</li> </ul>	<ul style="list-style-type: none"> <li>The Partnership Board, ICB board and its committees will all include at least one member who is independent of health or care organisations in the relevant footprint.</li> <li>Additional wording added <b>(7.3.3)</b>. Further detail will be in the provider selection regime regulations, once published.</li> <li>Para 1.4.5 sets out the ICB’s statutory duties on data protection. Section 7.2 outlines the ICB’s duties on Freedom of Information. The detail will be covered in separate policies.</li> <li>Additional wording added at <b>7.3.4</b>.</li> </ul>
<p><b>Section 8 – Terms and conditions of employees</b></p> <ul style="list-style-type: none"> <li>Is there any commitment to follow Agenda for Change conditions for existing staff transferred from CCGs and new ICB staff?</li> </ul>	<ul style="list-style-type: none"> <li>We will follow the national NHS employment commitment: “NHS people within the wider health and care system (below board level) affected directly by these legislative changes, including CCGs, NHS England and NHS Improvement and NHS providers, will receive an</li> </ul>

<ul style="list-style-type: none"> <li>• Duties of the Remuneration and Nomination Committee could include the alignment of remuneration to those within the West Yorkshire ISC system, for example Agenda for Change.</li> </ul>	<p>employment commitment to continuity of terms and conditions...this commitment is designed to provide stability and remove uncertainty during this transition to follow Agenda for Change conditions for existing staff transferred from CCGs and new ICB staff”</p> <ul style="list-style-type: none"> <li>• Additional wording added at <b>(8.6)</b>.</li> </ul>
<p><b>Section 9 - Public involvement</b></p> <ul style="list-style-type: none"> <li>• How does ICS plan to involve patients in the work of its ICB and ICP? Is any patient assurance planned at WYH level?</li> <li>• There should be mechanisms in place for people across joined up care to feedback and understand how this has been used to shape services.</li> </ul>	<ul style="list-style-type: none"> <li>• We are committed to involving local people in our work and in decision making at West Yorkshire and place level. Our ambition is to go much beyond solely meeting the statutory duty. This means we will be looking at a continuous cycle of active involvement in our decision-making committees as well as our system level programmes. Involving people and communities is one of our guiding principles. Healthwatch will be supporting this role, alongside local places and West Yorkshire programmes to ensure people remain at the centre of all we do.</li> <li>• Public and patient involvement is not limited to Board membership. We have independent co-opted public members on the Partnership Board, lay members on programme boards, a citizen panel for planned care, cancer community panel and youth collective voice group. We have strong partnerships with carers groups and organisations that have good relationships with seldom heard groups.</li> <li>• Each of our places will have independent representation on their decision-making committees. At a West Yorkshire level there will be</li> </ul>

<ul style="list-style-type: none"> <li>• Will the disabled community have representation in the ICB? Will there be representation and understanding of the needs of staff who have a disability or long term condition in the ICB – not all disabilities are visible.</li> <li>• Arrangements for public participation in meetings of the ICB Board (and any other bodies that it delegates its functions to) should be no less than current arrangements for public participation in the non-statutory ICS Board meetings and CCG meetings.</li> <li>• There need to be easy read minutes of ICB meetings as well as recordings of meetings which are publicly accessible. In addition, consideration should be given to BSL signed meetings and the availability of translation services. There needs to be greater clarity as to how the ICB will receive information about patient experience.</li> <li>• The constitution should specify that the ICB Annual (rolling) 5</li> </ul>	<p>independent members on our ICB Board and Integrated Care Partnership. Healthwatch will also be involved in these forums. Formal decision-making will be informed by the wider approach to public involvement set out in our communications and involvement plan and involvement framework.</p> <ul style="list-style-type: none"> <li>• The ICB will adopt the ten principles outlined by NHS England for working with people and communities. Amongst these principles is to put the voices of people and communities at the centre of decision-making and governance and to build relationships with excluded groups – especially those affected by inequalities, such as people with disabilities. The work is supported by our involvement framework, and the communication and involvement plan, and involvement principles which are continually being updated, and coproduced.</li> <li>• ICB decision-taking meetings will be held in public, and the public and patients will be encouraged to ask questions on the agenda items. All questions and answers will be publicly available. The Board will have a representative from Healthwatch</li> <li>• Arrangements for the ICB Board are under review.</li> <li>• The annual plan will provide accessible and understandable</li> </ul>
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YearPlan should be an accurate, current, readily accessible and understandable source of public information. There should be meaningful public consultation on the plan.

information. Wording at **9.2** added to confirm compliance with national and local involvement principles.

