



Interim guidance on the functions and governance of the integrated care board

NHS England and NHS Improvement may update or supplement this document during 2021/22. Elements of this guidance are subject to change until the legislation passes through Parliament and receives Royal Assent. We also welcome feedback from system and stakeholders to help us continually improve our guidance and learn from implementation. The latest versions of all NHS England and NHS Improvement guidance relating to the development of ICSs can be found at [ICS Guidance](#).

Version 1, August 2021

ICS implementation guidance

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

They exist to achieve four aims:

1. **improve outcomes** in population health and healthcare
2. **tackle inequalities** in outcomes, experience and access
3. enhance **productivity and value for money**
4. help the NHS support broader **social and economic development**.

Following several years of locally led development, and based on the recommendations of NHS England and NHS Improvement, the government has set out plans to put ICSs on a statutory footing.

To support this transition, NHS England and NHS Improvement are publishing guidance and resources, drawing on learning from all over the country.

Our aim is to enable local health and care leaders to build strong and effective ICSs in every part of England.

Collaborating as ICSs will help health and care organisations 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.

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About this document

This interim guidance sets out the proposed core components of integrated care board (ICB) governance arrangements as outlined in the [Health and Care Bill](#) and the [ICS Design Framework](#). It confirms the expected mandatory requirements (subject to legislation), as well as key considerations for system leaders as they design arrangements for April 2022.

The guidance should be read alongside the draft ICB Model Constitution and accompany guidance that will be provided to integrated care system (ICS) leaders on the statutory CCG functions to be conferred on ICBs.

Key points

- Integrated care boards will be statutory organisations that bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnerships across the ICS.
- Each ICB must be set out its governance and leadership arrangements in a constitution formally approved by NHS England and NHS Improvement.
- While preparations for these new arrangements are being made, all NHS organisations must continue to operate within the current legislative framework retaining any governance mechanisms necessary to maintain operational delivery (including patient safety, quality and financial performance).

Action required

ICS leaders, and designate ICB leaders as they are appointed, should proceed with preparations to design and implement ICB governance and leadership arrangements before April 2022 that fulfil the requirements set out in this interim guidance, including:

- recruiting required members of the ICB board, as well as any other locally agreed executive and non-executive roles.
- developing and submitting an ICB constitution for approval by NHS England and NHS Improvement, following engagement with relevant partners.

- develop a 'functions and decision map' showing the arrangements that will be put in place within the ICB and with ICS partners to support good governance and effective decision-making.

Other guidance and resources

- [ICS Design Framework](#)
- ICS guidance on NHS Futures site <https://future.nhs.uk/ICSGuidance/grouphome>

Introduction

The [Health and Care Bill](#) introduced in Parliament on 6 July 2021 confirmed the Government's intentions to introduce statutory arrangements for integrated care systems (ICSs) from April 2022, in line with NHS recommendations.¹

Subject to legislation being agreed each ICS will comprise an:

- integrated care partnership (ICP): the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS.
- integrated care board (ICB²) bringing the NHS together locally to improve population health and care.

The statutory guidance³ and statutory instruments establishing these components of each ICS cannot be made formally until the Bill has been enacted. However, system partners can now make the necessary preparatory arrangements for the expected new arrangements. These will build on, rather than replace, the partnerships that have developed over many years across systems and places.

This interim guide confirms the indicative mandatory governance requirements for ICBs as outlined in the Health and Care Bill and the [ICS Design Framework](#).

While preparations for these new arrangements are being made, all NHS organisations must continue to operate within the current legislative framework retaining any governance mechanisms necessary to maintain operational delivery (including patient safety, quality and financial performance).

¹ [Legislating for Integrated Care Systems: five recommendations to Government and Parliament](#)

² In the ICS Design Framework these were referred to as ICS NHS Bodies as in the Government's White Paper. In the Health and Care Bill these bodies are now referred to as integrated care boards. This term will therefore be used in this and future documentation.

³ NHS England and NHS Improvement will continue the dialogue with system leaders and key stakeholders on the drafting of the final statutory guidance. DHSC will similarly engage on proposed statutory guidance and instruments.

Using this guide

The first part of this interim guidance provides a summary of the indicative mandatory governance requirements for ICBs, as currently set out in draft legislation and NHS England and NHS Improvement policy. NHS England and NHS Improvement is committed to maintaining a permissive framework for systems, with mandatory requirements kept to a minimum. Annex 1 outlines further information that we would encourage system leaders to consider and use to inform local discussions.

The content in this guide should be read alongside:

- the draft model constitution for an integrated care board (ICB). This is based on the proposed requirements as set out in the Health and Care Bill. It will be refined based on engagement and any relevant amendments to the Bill as it goes through the Parliamentary process
- initial guidance on clinical commissioning group (CCG) functions to be conferred on ICBs.

These and other materials to support implementation will be made available to NHS organisations via the [NHS England and NHS Improvement ICS implementation hub](#), updated as necessary throughout the year.

The guide and accompanying resources:

- confirm the minimum requirements for ICB governance and board membership set out in the proposed legislation
- confirm NHS England and NHS Improvement's current expectations regarding board appointments and membership
- highlight other options and considerations for ICB governance arrangements, for example managing conflicts of interest.
- confirm the list of (CCG functions we expect to be applicable to ICBs (in a similar way to how they currently apply to CCGs).

We expect system leaders to use this guide and accompanying resources to inform the aspects of their transition plans set out in Table 1:

We will provide ICS leaders with a timeline setting out more fully the key activities and guidance on the ICB ‘readiness to Operate’ assurance process.

Table 1: Areas, activities and timescales

Area	Activity	Timescales
Constitution	<ul style="list-style-type: none"> • Start the development of the ICB constitution, subject to discussions with the regional team. • The Bill sets out that CCGs will propose the constitution for the first ICBs⁴ to NHS England and NHS Improvement, which will require confirmation that designate board members are supportive of its terms. • NHS England and NHS Improvement has developed a draft model constitution which system leaders and CCGs should use to guide the development of and consultation on their local version. 	<ul style="list-style-type: none"> • Development of the constitution to take place throughout the year. • A final version approved before the end of Q4 by NHS England and NHS Improvement.
Board recruitment	<ul style="list-style-type: none"> • Plan how the board of the ICB will be populated. 	<ul style="list-style-type: none"> • Designate chief executive identified by the end of November • Designate finance director, medical director, director of nursing and other executive roles in the ICB, before the end of Q4 • Designate partner members and any other designate ICB senior roles before the end of Q4.
Commissioning functions	<ul style="list-style-type: none"> • Confirm plans to ensure that commissioning functions are organised across the ICS footprint including apportioning between the ICB (system) level and ‘place’ level. 	<ul style="list-style-type: none"> • Discussions with partners and decisions on commissioning arrangements at system and place to be finalised by the end of Q3.
Functions and decision map	<ul style="list-style-type: none"> • Develop a ‘functions and decision map’ showing the arrangements with ICS partners to support good governance and dialogue with internal and external stakeholders. 	<ul style="list-style-type: none"> • Discussions and decisions on a functions and governance map to take place throughout the year. • A final ‘functions and decision map’ due before the end of Q4 to be completed alongside the model constitution.

⁴ CCGs will be legally responsible for the development of ICB constitutions, but we expect this process to be led by the designate ICS chair and CEO. System partners must be engaged in the development of the constitution.

Overview of core ICB governance components

NHS England and NHS Improvement expect that ICBs will be created from April 2022, with the functions currently performed by CCGs conferred on ICBs. Each CCG's staff, assets and liabilities will be transferred to the relevant ICB, and some NHS England and NHS Improvement direct commissioning functions will be delegated.

Although ICBs will take on these CCG functions, they will bring health and care organisations together in new ways, with a greater emphasis on collaboration and shared responsibility for the health of the local population. ICBs will also have flexibilities to deliver commissioning activities differently - for example, to exercise their functions through, or jointly with, providers, NHS England and NHS Improvement, a local authority or a combined authority.

These changes offer a variety of opportunities for organisations within the NHS, and system partners, to work more collaboratively in the planning and delivery of services to tackle health inequalities and improve quality and outcomes.

This will require governance arrangements that support collective accountability between partner organisations for whole-system delivery and performance. These arrangements should be proportionate, and they must facilitate transparent decision-making and foster the culture and behaviours that enable system working.

Table 2 sets out the core components of ICB governance arrangements. The rest of this guide details the 'must do' requirements for each component and key considerations to inform local discussions on the design of statutory ICBs and statutory ICPs. Systems will want to consider a much wider range of governance vehicles to conduct their business: this list is therefore not exhaustive but provides a framework for systems to build on.

Table 2: Core components of ICB governance arrangements and expectations

Core component	Expectation
Integrated care partnership (ICP) <i>statutory</i>	<ul style="list-style-type: none"> • Each ICS area will have an ICP (a committee, not a body) at system level established by the ICB and relevant local authorities as equal partners and bringing together organisations and representatives concerned with improving the care, health and wellbeing of the population. • The ICP to have a specific responsibility to develop an integrated care strategy. • Each ICB will need to align its constitution and governance with the ICP.
Integrated care board <i>statutory</i>	<ul style="list-style-type: none"> • ICBs will be established as new statutory organisations, to lead integration within the NHS. • The ICB will have a unitary board, responsible for ensuring the body plays its role in achieving the four purposes • Minimum requirements for board membership will be set in legislation. We have set further minimum expectations for board membership. • Each board will be required to establish an audit committee and remuneration committee • All ICBs will need to put arrangements in place to ensure they can effectively discharge their full range of duties and functions. This is likely to include arrangements for other committees and groups to advise and feed into the board, and to exercise functions delegated by the board.
Place-based partnerships	<ul style="list-style-type: none"> • ICBs will be able to arrange for functions to be exercised and decisions to be made, by or with place-based partnerships, through a range of different arrangements. The ICB will remain accountable for NHS resources deployed at place-level. • Each ICB should set out the role of place-based leaders within its governance arrangements.
Provider collaborative (may be at sub system, system or supra-system level)	<ul style="list-style-type: none"> • Provider collaboratives will agree specific objectives with one or more ICB, to contribute to the delivery of that system’s strategic priorities. The members of the collaborative will agree together how this contribution will be achieved. • The ICB and provider collaboratives must define their working relationship, including participation in committees via partner members and any other local arrangements, to facilitate the contribution of the provider collaborative to agreed ICB objectives.

The ICP and the ICB

ICP guidance will be issued by the Department of Health and Social Care (DHSC). It will be jointly developed between DHSC, NHS England and NHS Improvement and the Local Government Association (LGA). The proposed legislation and ICS Design Framework set out that:

- The ICP will be established locally and jointly by the relevant local authorities and the ICB, evolving from existing arrangements and with mutual agreement on its terms of reference, membership, ways of operating and administration.
- Members must include local authorities (that are responsible for social care services in the ICS area) and the local NHS (represented at least by the ICB).
- The ICP will have a specific responsibility to develop an 'integrated care strategy'⁵ for its whole population (covering all ages) using the best available evidence and data, covering health and social care (both children's and adult's social care), and addressing health inequalities and the wider determinants which drive these inequalities.
- The strategy must set out how the needs assessed in the Joint Strategic Needs Assessment(s) for the ICB area are to be met by the exercise of NHS and local authority functions. This will be complemented by the Joint Health and Wellbeing Strategy prepared by each Health and Wellbeing Board in the geographical area of the ICS.
- Each ICP should champion inclusion and transparency and challenge all partners to demonstrate progress in reducing inequalities and improving outcomes. It should support place-and neighbourhood-level engagement, ensuring the system is connected to the needs of every community it covers.

[Key considerations to support system leaders as they develop local arrangements between the ICB and ICP including the development and delivery of the integrated care strategy can be found in section A, Annex 1.](#)

⁵ We expect the inaugural ICP strategy will be developed in 2022/2023

The integrated care board

ICBs will bring partner organisations together in a new collaborative way with common purpose. They will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place.

Table 3: Functions of the integrated care board

1	Developing a plan to meet the health and healthcare needs of the population (all ages) within their area, having regard to the Partnership's strategy.
2	Allocating resources to deliver the plan across the system, determining what resources should be available to meet population need in each place and setting principles for how they should be allocated across services and providers (both revenue and capital). Financial rules will apply to ensure delivery of key national commitments, such as the Mental Health Investment Standard and the primary medical and community health services funding guarantee.
3	Establishing joint working arrangements with partners that embed collaboration as the basis for delivery within the plan.
4	Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations.
5	<p>Arranging for the provision of health services in line with the allocated resources across the ICS through a range of activities including:</p> <ul style="list-style-type: none"> a) putting contracts and agreements in place to secure delivery of its plan by providers b) convening and supporting providers (working both at scale and at place) to lead⁶ major service transformation programmes to achieve agreed outcomes c) support the development of primary care networks (PCNs) as the foundations of out-of-hospital care and building blocks of place-based partnerships,

⁶ It is expected that the ICB will be able to delegate functions to statutory providers to enable this.

	<p>including through investment in PCN management support, data and digital capabilities, workforce development and estates</p> <p>d) working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care.</p>
6	Leading system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers.
7	Leading system-wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care.
8	Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes.
9	Through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in achieving wider goals of social and economic development and environmental sustainability.
10	Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability.
11	Planning for, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.
12	Functions to be delegated by NHS England and NHS Improvement include commissioning of primary care and appropriate specialised services.

Statutory CCG functions to be conferred on ICBs

Statutory functions, like those currently exercised by CCGs, will be conferred on ICBs from 1 April 2022, along with the transfer of all CCG staff, assets and liabilities (including commissioning responsibilities and contracts). Relevant duties of CCGs include those regarding health inequalities, quality, safeguarding, children in care and children and young people with special educational needs and (SEN) or disability.⁷

The full expected list of CCG functions to be conferred will be made available to NHS organisations via the [NHS England and NHS Improvement ICS implementation hub](#).

Delegating direct commissioning functions to ICBs

It is the intention to delegate some of the direct commissioning functions of NHS England and NHS Improvement to ICBs as soon as operationally feasible from April 2022.

Our expectation is that from April 2022 ICBs will:

- assume delegated responsibility for Primary Medical Services (currently delegated to all CCGs, and continuing to exclude Section 7A Public Health functions)
- be able to take on delegated responsibility for Dental (Primary, Secondary and Community), General Optometry, and Pharmaceutical Services (including dispensing doctors and dispensing appliance contractors)
- establish mechanisms to strengthen joint working between NHS England and NHS Improvement and ICSs, including through joint committees, across all areas of direct commissioning (in systems where they are not already delegated).

By April 2023, all ICBs will have:

- taken on delegated responsibility for dental (primary, secondary and community), general ophthalmic services, and pharmaceutical services
- taken on delegated commissioning responsibility for a proportion of specialised services (subject to system and service readiness) with national standards and access policies remaining at a national level
- worked collaboratively with our organisation to determine whether some Section 7A Public Health services, and Health and Justice, Sexual Assault and Abuse

⁷ Further guidance will be developed to support the transition of functions to ensure ICSs deliver for babies, children and young people.

Service commissioning functions will be delegated, with decisions on the appropriate model and timescale.

Commissioning healthcare for serving members of the Armed Forces and their families registered with defence medical services, veterans' mental health and prosthetic services will remain with NHS England and Improvement.

Decision-making within an ICB

ICBs must determine how and where decisions are taken. We expect ICBs to publish a Scheme of Reservation and Delegation (SoRD) which sets out (i) functions that are reserved to the board (ii) functions that have been delegated to an individual or to committees and sub committees (iii) functions delegated to another body or to be exercised jointly with another body.

ICBs must also develop a functions and decision map⁸ that:

- is locally defined
- sets out where decisions are taken and outlines the roles of different committees/partnerships
- is easily understood by the public.

[Key principles for effective discharge of functions and associated decision-making can be found in section B, Annex 1.](#)

Board of the ICB

The ICB will have a unitary board, which means all directors are collectively and corporately accountable for organisational performance. The purpose of the board is to govern effectively and in doing so, build patient, public and stakeholder confidence that their healthcare is in safe hands. The board will be responsible for:

- formulating strategy for the organisation
- holding the organisation to account for the delivery of the strategy; by being accountable for ensuring the organisation operates effectively and with

⁸ A high-level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. This should include any decision-making responsibilities that are delegated to other committees ie place-based partnership / provider collaboratives.

openness, transparency and candour and by seeking assurance that systems of control are robust and reliable

- shaping a healthy culture for the organisation and the wider ICS partnership.

[A list of typical responsibilities that could sit within the board of the ICB and key considerations for its operation can be found in section C, Annex 1.](#)

Membership of the ICB board

We will expect every ICB to establish board roles as required to carry out its functions effectively, building on the minimum membership set out below in Table 4.

Table 4: Minimum membership of the unitary board of the ICB.

Type	Role	Appointment and expectations
<i>Independent non-executive members</i>	Chair	<ul style="list-style-type: none"> • appointed by NHS England and NHS Improvement (with Secretary of State approval). The chair must be independent and cannot hold a role in another health and care organisation within the ICB area.
	A minimum of two other independent non-executive members	<ul style="list-style-type: none"> • appointed by the ICB and are subject to the approval of the chair • these members will normally not hold positions or offices in other health and care organisations within the ICS footprint
<i>Executive roles</i>	Chief Executive	<ul style="list-style-type: none"> • Must be employed by / seconded to the ICB
	Chief Finance Officer	<ul style="list-style-type: none"> • Must be employed by / seconded to the ICB
	Director of Nursing	<ul style="list-style-type: none"> • Must be employed by/seconded to the ICB
	Medical Director	<ul style="list-style-type: none"> • Must be employed by/seconded to the ICB
<i>Partner members (a minimum of three)</i>	At least one member drawn from NHS trusts and foundation trusts that provide services within the ICS's area	<ul style="list-style-type: none"> • We expect the partner member(s) from NHS trusts/foundation trusts will often be the chief executive of their organisation

	At least one member drawn from the primary medical services (general practice) providers within the ICB area	<ul style="list-style-type: none"> We expect the member drawn from primary medical services providers to engage and bring perspectives from all primary care providers, including primary care networks
	At least one member drawn from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the area of the ICB.	<ul style="list-style-type: none"> We expect this partner member will often be the chief executive of their organisation or in a relevant executive-level local authority role
<i>All members of the ICB</i> <i>*ICBs will be able to supplement the minimum board positions</i>	As listed above and additional members.	<p>Each member of the ICB must:</p> <ul style="list-style-type: none"> By law be subject to the approval of the Chair (excluding the CEO, who is approved by NHS England and NHS Improvement). Comply with the criteria of the “fit and proper person test”⁹ Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles). Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification. Meet the eligibility criteria set out in the constitution of the ICB

The constitution of the ICB must set out board roles, the process of appointing the partner members and eligibility criteria that must be fulfilled. The constitution must be submitted to and approved by NHS England and NHS Improvement.

⁹ We anticipate that regulations regarding the “fit and proper person test” will apply to ICBs when established. We expect that designate board member appointments will comply with these principles. These includes agreement that evidence of compliance will be shared with the relevant authority and a commitment to regular review of continued compliance.

All three partner members will be full members of the unitary board, bringing knowledge and a perspective from their sectors, but not acting as delegates of those sectors.

The Bill states that the partner members are to be 'nominated jointly' by their respective sector and we expect details regarding the organisations that can take part in any nomination process to be set out in regulations later this year. We will expect all board members to be selected based on the skills and experience required to fulfil the roles, and assessed to ensure they meet the 'fit and proper persons' test and the eligibility criteria set out in the constitution of the ICB. Arrangements for appointing designate partner members must therefore combine nomination and assessment in the selection process.

[Key considerations for the development of the ICS constitution including the membership of the board can be found in section D, Annex 1.](#)

In addition to the required board roles, the ICB is expected to establish leadership structures and accountability for the organisation's responsibilities in delivering agreed local and national priorities. It will be important that boards have strong leadership on issues that impact upon organisations and staff across the ICS, including the people agenda and digital transformation.

The [ICS Design Framework](#) sets out that ICB leadership arrangements must include clear accountability within the organisation and named SROs (registered professionals or with equivalent experience) for their people, workforce and digital and data functions.

Remuneration

ICB Executives will be employed by or seconded to the ICB and paid as employees.

Independent chairs and non-executive members will be remunerated for their time. This should be in line with national guidance, which will be made available to NHS organisations via the [NHS England and NHS Improvement ICS implementation hub](#).

The legislation will also allow for the 'partner' members to be remunerated where relevant. What is appropriate may vary for different members, depending on their circumstances. For example, a trust or council chief executive paid for a full-time role by their trust/local authority should not expect to be paid again by the ICB, but the member drawn from primary medical service providers may not be otherwise employed, or may be paid on a sessional basis, and therefore may be remunerated for their role on the board.

Remuneration for board members not employed by the ICB is for the board to determine but all bodies should ensure that no members are paid twice for the same time by different organisations.

Equality, diversity and inclusion

Effective equality, diversity and inclusion (EDI) leads to improved health delivery and greater staff and patient experiences of the NHS¹⁰. ICBs must demonstrate how they are driving EDI, including to ensure that:

- the workforce (at all levels) represents the diversity of the NHS
- people working and learning in ICBs can develop and thrive in a compassionate and inclusive environment
- there is a whole system view of population health needs, health inequalities and expected outcome improvements for those groups including by setting clear priorities for tackling health inequalities, and address overlap between workforce and wider population inequalities
- there is an organisational culture that promotes inclusion and embraces diversity
- members of the unitary board and employees display the highest standards of inclusive behaviour and are adhering to the competencies expected of them
- they are utilising data to improve performance of organisations, including the use of the NHS Workforce Race Equality Standard (WRES) as a key performance indicator.

ICBs will also be subject to section 149 of the Equality Act 2010 and the specific equality duties.

Further information on the people function of ICBs will be made available to NHS organisations via the [NHS England and NHS Improvement ICS implementation hub](#).

¹⁰ The [NHS People Plan](#) set out key expectations of NHS organisations to ensure the NHS will be open and inclusive. System partners must act on these expectations as they develop interim ICB arrangements.

ICB committees

ICBs must ensure they can effectively discharge their full range of functions. This is likely to include establishing committees of the ICB to support the board and exercise any delegated functions.

The legislation is expected to require all ICBs to establish an audit committee and remuneration committee. Alongside this, there will be flexibility in how they establish and deploy the use of other committees. They would have the power to:

- appoint individuals who are not board members or staff of the ICB to be members of any committee it has established
- delegate any of its functions to be exercised by or jointly with another ICB, an NHS trust, NHS foundation trust, NHS England, local authority, combined authority, or any other body that may be prescribed in Regulations

Where an ICB has delegated any of its functions to be exercisable jointly by itself and another such body/bodies, the ICB and other body/bodies may arrange for the delegated function(s) to be exercised by a joint committee.

Boards may also be supported by an executive group including, for example, other professional and functional leads, to manage the day-to-day running of the organisation.

[Key considerations for the establishment of different types of committees can be found in section E, Annex 1.](#)

Providers and provider collaboratives

From April 2022 trusts providing acute and/or mental health services are expected to be part of one or more provider collaboratives. Community trusts, ambulance trusts and non-NHS providers (eg community interest companies, social care providers) should participate in provider collaboratives where this is beneficial for patients and makes sense for the providers and systems involved.

Provider collaboratives will agree specific objectives with one or more ICBs, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together how this contribution will be achieved.

The ICB and provider collaboratives must define their working relationship, including participation in committees via partner members and any supporting local arrangements, to facilitate the contribution of the provider collaborative to agreed ICB objectives.

We expect:

- The ICB could arrange for its commissioning functions to be delegated to one or more NHS trusts and/or foundation trusts, including when working as provider collaboratives (this would require a lead provider arrangement or for the delegation to be to all the trusts involved). ICBs will continue to be held to account for the way in which the function has been discharged. An ICB would have to continue to monitor how the delegation was operating and whether it remained appropriate.
- Another option would be for the ICB to arrange for its commissioning functions to be delegated to a joint committee of itself and another/other NHS trust(s) and/or foundation trust(s).

Further information on provider collaboratives can be found on the [NHS England and NHS Improvement website](#)

Place-based partnerships and the ICB

The governance arrangements of place-based partnerships (PBPs) and their relationship to the board of the ICB should be agreed by the board of the ICB with place leaders. They will depend on the agreed functions and responsibilities that sit with PBPs, local relationships as well as existing structures.

Table 5 summarises the broad types of governance arrangements that could be established to support PBPs to make decisions between the appropriate partners to support the aims of the partnership, if the Bill is passed in its current form. Further consideration will need to be given to the decision-making arrangements of committees, and agreed with statutory bodies where they relate to the delegation of statutory functions. For example, agreeing the approaches to managing disagreement in their terms of reference and whether a lead member of a committee is required.

Table 5: Governance options for place-based partnerships¹¹

<p>Consultative forum</p> <p>Helpful for engaging the widest range of partners to discuss and agree shared strategic direction together.</p>	<p>A collaborative forum to inform and align decisions by relevant statutory bodies, such as the ICB or local authorities, in an advisory role.</p> <p>In this arrangement, the decisions of statutory bodies should be informed by the consultative forum.</p>
<p>Individual executives or staff</p> <p>Helpful for engaging partners in the decision-making of statutory bodies, while retaining a single SRO for decisions.</p>	<p>Statutory bodies may agree individual members of staff to exercise delegated functions, and they may convene a committee to support them, with membership which includes representatives from other organisations.</p> <p>In this instance, the individual could become the SRO for the place in their body, enabling budgets to be defined for the committee and managed through their internal management and reporting arrangements. The individual director could be a joint appointment, between the ICB and local authority, or statutory NHS provider, and could have delegated authority from those bodies.</p>

¹¹ The governance options are not mutually exclusive; places may draw upon multiple versions of the options for different sets of business and decision-making as appropriate and could use a single forum for multiple purposes. It may be possible to use and amend existing forums to support decision-making.

<p>Committee of the ICB</p> <p>Helpful for making decisions of the ICB based on a range of views</p>	<p>A committee provided with delegated authority to make decisions about the use of NHS resources, including the agreement of contracts for relevant services. This committee could include members from outside the organisation. However, the decisions reached are the decisions of the ICB, in line with the organisation's scheme of delegation.</p> <p>The terms of references and scope are set by the ICB and agreed to by the committee members. A delegated budget can be set by the ICS NHS body to describe the level of NHS resources available to cover the remit of the committee.</p>
<p>Joint committee</p> <p>Helpful for making joint decisions between relevant partners</p>	<p>A committee established between partner organisations, such as the ICB, local authorities, statutory NHS providers or NHS England and NHS Improvement. The committee may appoint representatives of non-statutory providers to participate in the committee or attend meetings to take part in discussions without being members, but only where the convening statutory bodies consider it appropriate.</p> <p>The relevant statutory bodies can agree to delegate defined decision-making functions to the joint committee in accordance with their respective schemes of delegation. A budget may be defined by the bodies delegating statutory functions to the joint committee, to provide visibility of the resources available to deliver the committee's remit.</p>
<p>Lead provider</p> <p>Helpful for giving provider leaders greater ownership and direction around the delivery and coordination of services.</p>	<p>A lead provider manages resources and delivery at place-level, as part of a provider partnership, under a contract with the ICB and/or local government, having lead responsibility for delivering the agreed outcomes for the place (including national standards and priorities) for the defined set of services.</p> <p>The lead provider would sub-contract other providers within the scope of the place-based delivery partnership. They can agree how NHS resources are spent within the payment envelope agreed with the ICB, complying with the terms of the contract, and establish governance with partnering providers to support delivery.</p>

Where place-based partnerships agree with statutory bodies (for example the ICB, NHS providers or local government) to take on delegated statutory functions for the place, the relevant bodies will retain accountability for these functions and must be satisfied the place-based partnership is able to manage the functions appropriately.

[Further information on place-based partnerships membership can be found in section F, Annex 1.](#)

Further information on place-based partnerships will be made available to NHS organisations via the [NHS England and NHS Improvement ICS implementation hub](#).

ICBs and managing conflicts of interest

Measures for the management of conflicts of interest (Col) must allow ICBs to function as intended in legislation. The guiding principle for Col policy is to ensure that decisions are made in the public interest by avoiding any undue influence.

[Current NHS guidance](#) defines a conflict of interests as follows:

“A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.”

The routine declaration and management of Cols is widely accepted as a key aspect of good governance, and the Bill will put in place statutory requirements in relation to the management of Cols (similar to the provision currently applied to CCGs). This includes a requirement to maintain one or more registers of interests for (i) members of the board (ii) members of its committees or sub-committees (iii) its employees. At the same time, members of the board or committees will need to abide by their own organisation’s Col policies

The management of Cols is critical both in maintaining public confidence in NHS decision-making and in protecting staff from allegations that they have acted inappropriately. Boards are encouraged to set aside the necessary time to debate and explore these issues as part of their developmental journey.

[To support ICBs with COIs, section G of Annex 1 sets out several principles we expect system leaders to consider as they develop local arrangements.](#)

Conclusion

This interim guidance seeks to support NHS organisations and system leaders as they prepare to establish the governance arrangements for ICBs. It does not go into detail on the 'how', or the benefits of different approaches, which should be determined through discussions between local partners as shadow arrangements are established.

This guide will be supplemented or replaced (as relevant) during 2021/22 by:

- Sharing learning from systems as they develop and implement governance arrangements
- Publication of full statutory guidance (statutory guidance will be based on the final legislation, learning from systems and feedback from stakeholders).

Annex 1: Considerations for the development of local governance arrangements for ICBs

This annex has been drafted based on the content of the Health and Care Bill as it stands at the time of writing. It provides further information for local consideration to support the development and implementation of the mandatory requirements as outlined in this document. It is not an exhaustive list but outlines some key areas and points to inform discussions on the design of local governance arrangements.

Specifically, when designing the next phase of ICS development, system leaders should:

- build on existing local arrangements where they are effective
- support our ambition that all ICSs are successful in integrating care to deliver the NHS Long Term Plan and the four core purposes of ICSs as described in [Integrating care: Next steps to building strong and effective integrated care systems across England](#)
- develop arrangements rooted in underlying principles of subsidiarity and collaboration
- ensure their governance arrangements are proportionate; add positive value; and foster culture, behaviours and processes that enable system working.

Learning from system partners as they have developed collaborative arrangements has highlighted the importance of ensuring:

- **form follows function:** arrangements must support the core purpose for ICSs to improve outcomes, tackle inequalities, increase productivity and value for money and promote social and economic development
- **bureaucracy is minimised:** arrangements should facilitate streamlined, efficient and timely decision-making
- **accountabilities are clear and balanced:** there is strong leadership across partners and clear understanding of the partnership as well as organisation accountabilities to patients, the public, staff and partners.

- **the principle of subsidiarity is upheld:** decisions should be taken as close to local communities as possible, and across a large footprint where there are benefits from economies of scale.

This table sets out key considerations to support local discussions on the design and development of local governance arrangements.

Area	Key considerations
<p>Section A</p> <p>Key considerations for the development of local arrangements between the ICB and ICP</p>	<p>The ICB will have a key role in establishing the membership of the ICS Partnership (jointly with local authorities). It will be important to consider:</p> <ul style="list-style-type: none"> • whether the membership is representative of the different population groups it serves to ensure involvement of those who are best placed to respond to the diverse health and care needs of the respective population groups • the capacity of partners to contribute effectively, in some systems for instance, some partners will be engaged on multiple footprints • evolving membership of the ICP as required to best meet the needs of the local population • roles of organisations involved in the ICB either at board, place or neighbourhood level
	<p>Members of the ICP will also be engaging with the ICB at system, place and neighbourhood (in many cases). The ICB must consider:</p> <ul style="list-style-type: none"> • How joint working with partners at all levels will support progress in reducing inequalities and improving outcomes? • How the ICP, the ICB and place-based arrangements work together to maximise efforts and avoid duplication? • How ICPs and ICBs will develop formal agreements for engaging and embedding the VCSE sector in system-level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector. These arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level. Further guidance on working with the VCSE sector will be made available to NHS organisations via the NHS England and NHS Improvement ICS implementation hub.
	<p>The development and delivery of the integrated care strategy will require all partners to work closely together to determine how the needs of different population groups and communities could be addressed and form part of a joint strategy. The ICB must consider:</p> <ul style="list-style-type: none"> • How the ICB Plan supports the delivery of the integrated care strategy to ensure strategic alignment with the agreed values, goals, objectives, initiatives and cross cutting issues • How the ICB will share intelligence with the ICP in a timely manner to ensure the evolving needs of the local health service is widely understood and opportunities for at scale collaboration are maximised?

	<ul style="list-style-type: none"> • How the strategy fits in with the ICB's own plans and priorities, and how assurance is provided to the ICP on delivery? • How clinical and care professional will be involved and invested in the development and delivery of ICS strategy and planning and integrated into system decision-making at all levels, and how they will be given the appropriate protected time, support and infrastructure to carry out this work. Further guidance on clinical and professional leaders will be made available to NHS organisations via the NHS England and NHS Improvement ICS implementation hub.
<p>Section B</p> <p>Six key principles for effective discharge of functions and associated decision-making</p>	<ul style="list-style-type: none"> • Subsidiarity: arrangements should be designed to facilitate decisions being taken as close to local communities as possible, and at a larger scale where there are clear benefits from collaborative approaches and economies of scale • Population-focused vision: decisions should be consistent with a clear vision and strategy that reflects the four core purposes • Shared understanding: partners should have a collective understanding of the opportunities available by working together and the impact of individual organisational decisions on other parts of the system • Co-design and co-production: addressing system challenges and decision-making should involve working with people, communities, clinicians and professionals in an equal way, sharing influence, skills and experience to design, deliver and monitor services and projects • Timely access to information and data: system partners should share accurate and complete data (quantitative and qualitative) in an open and timely manner to enable effective decision-making • Clear and transparent decision-making: system partners should work in an open way ensuring that decision-making processes stand up to independent scrutiny.
<p>Section C</p> <p>List of typical responsibilities to be led by a board as well as key considerations for its operation</p>	<p>Partners may wish to consider the following typical responsibilities that could sit with the board of the ICB:</p> <ul style="list-style-type: none"> • Setting the overall vision, strategy and approving the business plan • Determining which decisions it will reserve to itself and which it will delegate • Ensuring high standards of corporate governance and personal conduct • Holding the executive to account for monitoring the performance of the body against core financial and operational objectives • Providing effective financial stewardship • Promoting effective dialogue between the ICB and other partners, including NHS England and Improvement, the ICP, providers, councils, representatives of local communities and people who use services.

	<ul style="list-style-type: none"> • Putting in place effective arrangements for place-based working with partners • Ensuring that the ICB purposefully develops arrangements for effective clinical and care professional leadership throughout the system • Creating an organisational culture that encourages and enables system working, building partnerships with people and communities and utilising feedback to improve services • Ensuring legal duties are discharged effectively and foster the development of policies, processes and initiatives that promote equality and address health inequalities • Delivering system priorities for and through the ICS's 'one workforce' across the health and care sector, local government, the third sector, volunteers and informal carers • Ensuring workforce strategies are built on the principles and commitments set out in the NHS People Plan and the People Promise • Developing a compassionate and inclusive leadership model with sufficient capacity and capabilities to fulfil system roles • Aligning the ICB assets to contribute to population health improvement as anchor institutions. <p>Ensuring their decision-making processes are informed by, and shape, the intelligence which provides an understanding of local people's needs, and information on how the system is performing (using joined up data/ digital capabilities to understand local priorities, track delivery of plans, monitor and address risks and drive continuous improvement in performance and outcomes).</p>
<p>Section D</p> <p>Key considerations for the development of the ICS constitution including the membership of the board</p>	<ul style="list-style-type: none"> • How the board can be best served by members drawn from a wide diversity of backgrounds and sectors, including how the board composition reflects the diverse communities they serve • The overall size of the board, ensuring this allows for effective decision-making • The overall balance of the membership between the different types of members to ensure that no one individual or group dominates decision-making • The skills and experience required across members (for NEDS, including the skills and experience necessary to be an effective chair of the ICB audit committee and remuneration committee) • How to ensure the board has connection to the local area (for example through specifying at least NEDs living or working in the area; or having experience in public, patient or community engagement) • Ensuring non-executive directors and partner members have enough time to meet their board responsibilities

	<ul style="list-style-type: none"> • How partner members will be supported to manage the duality of their roles in the ICB and the sector/organisation from which they are drawn, including any conflict of interest arising • Whether other specified individuals should be participants or observers at board meetings to inform the board's decision-making and the discharge of its functions (but cannot vote) 								
<p>Section E</p> <p>Committees of the ICB</p>	<p>We expect each ICB will be required to establish an audit committee and remuneration committee:</p> <p>Audit committee</p> <ul style="list-style-type: none"> • 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 independent board member who has qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters. <p>Remuneration Committee</p> <ul style="list-style-type: none"> • This committee is accountable to the board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB. • The Remuneration Committee will be chaired by an independent board member other than the Chair or the Chair of Audit Committee. <p>In addition, we anticipate that the board may wish to consider the following types of committees:</p> <table border="1" data-bbox="472 1294 1412 1993"> <thead> <tr> <th data-bbox="472 1294 730 1368">Type</th> <th data-bbox="730 1294 1412 1368">Overview</th> </tr> </thead> <tbody> <tr> <td data-bbox="472 1368 730 1697">Committee</td> <td data-bbox="730 1368 1412 1697"> <ul style="list-style-type: none"> • Committee established by the board for the purpose of exercising ICS functions that the board chooses to delegate, providing assurance to the board or providing formal advice to the board. • The detailed arrangements for committees will be set out in the Scheme of reservation and delegation, the Standing orders and the Committee terms of reference. </td> </tr> <tr> <td data-bbox="472 1697 730 1816">Sub-committee</td> <td data-bbox="730 1697 1412 1816"> <ul style="list-style-type: none"> • With the agreement of the board a committee may establish sub-committees to assist with its responsibilities </td> </tr> <tr> <td data-bbox="472 1816 730 1993">Advisory/ task and finish groups</td> <td data-bbox="730 1816 1412 1993"> <ul style="list-style-type: none"> • The board may establish advisory groups and task and finish groups which have no decision-making powers but that may provide advice, propose solutions and recommendations. </td> </tr> </tbody> </table>	Type	Overview	Committee	<ul style="list-style-type: none"> • Committee established by the board for the purpose of exercising ICS functions that the board chooses to delegate, providing assurance to the board or providing formal advice to the board. • The detailed arrangements for committees will be set out in the Scheme of reservation and delegation, the Standing orders and the Committee terms of reference. 	Sub-committee	<ul style="list-style-type: none"> • With the agreement of the board a committee may establish sub-committees to assist with its responsibilities 	Advisory/ task and finish groups	<ul style="list-style-type: none"> • The board may establish advisory groups and task and finish groups which have no decision-making powers but that may provide advice, propose solutions and recommendations.
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	Joint committee	<ul style="list-style-type: none"> The ICB will have the power to establish joint committees with certain other organisations to exercise ICB or the other body's / bodies' functions jointly.
<p>Learning from system partners has highlighted the importance of committees to support with functions and having wider system leadership responsibilities. We expect that the ICB will want to consider the different functions and duties committees could take on including those related to:</p> <ul style="list-style-type: none"> Finance Performance Quality¹² Workforce / people Digital Transformation Transitions <p>The board should ensure that membership of any committee it establishes has the right combination of skills, experience and knowledge. It should also ensure committees do not make decisions in silo, particularly where there are significant implications for the organisation.</p> <p>Key considerations and questions when deciding on establishing committees:</p> <ul style="list-style-type: none"> The board is ultimately accountable for any committee established, and decisions taken by that committee. The audit committee and remuneration committee must be chaired by an independent non-executive and composed of independent non-executives and/or individuals who are otherwise independent. Governance arrangements should include appropriate reporting arrangements to ensure the ICB has the necessary visibility and assurance of the discharge of these functions by any ICB board members or ICB staff, committees or organisations to which ICB functions have been delegated. Can committees operate transparently? Are the proposed statutory functions of the committee really board functions or are they executive functions? Is a standing committee required - or can the task be undertaken by a short life working group? Can proposed functions be delegated instead of being carried out by the whole board of the ICB? Is the committee being established because of one major incident or issue? is it a proportionate response? 		

¹² The [NQB has issued a Position Statement](#) for those working in health and care systems. Endorsed by Lord Darzi, the Position Statement emphasises the importance of prioritising the delivery of high-quality care at this crucial time of transition and sets out some core principles and consistent operational requirements for quality oversight in systems

	<ul style="list-style-type: none"> Does the creation of the committee reduce clarity of role or create lack of alignment between other committees of the board and the board itself?
Section F Place-based Partnerships membership	<p>It will be for local partners to determine PBP membership. We expect they will include representation from the following:</p> <ul style="list-style-type: none"> Primary care provider leadership, represented by PCN clinical directors or other relevant primary care leaders Providers of acute, community and mental health services, including representatives of provider collaboratives where appropriate People who use care and support services, and their representatives including Healthwatch Local authorities Social care providers The VCSE sector The ICB
Section G Managing Conflicts of Interest principles	<p>We propose the following principles to support ICBs in managing Cols:</p> <ul style="list-style-type: none"> Decision-making must be geared towards meeting the statutory duties of ICBs at all times, including the triple aim¹³. Any individual involved in decisions relating to ICB functions must be acting clearly in the interests of the ICB and of the public, rather than furthering direct or indirect financial, personal, professional or organisational interests. ICBs have been created to give statutory NHS providers, local authority and primary medical services (general practice) nominees a role in decision-making. These individuals will be expected to act in accordance with the first principle, and it should not be assumed that they are personally or professionally conflicted just by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations. The personal and professional interests of all ICB board members, ICB committee members and ICB staff who are involved in decision taking need to be declared, recorded and managed appropriately. Declarations must be made as soon as

¹³ It is a proposed common duty for NHS bodies that plan and commission services (NHS England and ICBs) and that provide services (Trusts and Foundation Trusts).

It will oblige these bodies to consider the effects of their decisions on:

the health and wellbeing of the people of England

the quality of services provided or arranged by both themselves and other relevant bodies

the sustainable and efficient use of resources by both themselves and other relevant bodies

practicable after the person becomes aware of the conflict or potential conflict and, in any event, within 28 days of the person becoming aware. This is already standard practice in existing NHS organisations such as CCGs. This includes being clear and specific about the nature of any interest, and about the nature of any conflict that may arise regarding a particular decision.

- Actions to mitigate CoIs should be proportionate and should seek to preserve the spirit of collective decision-making wherever possible. Mitigation should take account of a range of factors including the impact that the perception of an unsound decision might have, and the risks and benefits of having a particular individual involved in making the decision.
- ICBs should clearly distinguish between those individuals who should be involved in formal decision taking, and those whose input informs decisions, including shaping the ICB's understanding of how best to meet patients' needs and deliver care for their populations. The way CoI are managed should reflect this distinction. For example, where independent providers (including the VCSE sector) hold contracts for services it would be appropriate and reasonable for the body to involve them in discussions, for example about pathway design and service delivery, particularly at place-level. However, this would be clearly distinct from any considerations around contracting and commissioning, from which they would be excluded.
- As is already established practice in the NHS, where decisions are being taken as part of a formal competitive procurement of services, any individual who is associated with an organisation that has a vested interest in the procurement should recuse themselves from the process.
- The way conflicts of interest are declared and managed should contribute to a culture of transparency about how decisions are made.

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