



Guidance to clinical commissioning groups on preparing integrated care board constitutions

13 May 2022

About this document

NHS England¹ is issuing this guidance under the new section 14Z26(6) of the NHS Act 2006 as amended by the Health and Care Act 2022 (the Act), and clinical commissioning groups (CCGs) must have regard to it. It sets out and explains the key requirements for integrated care board (ICB) constitutions, as well as where there is local flexibility. It also explains the steps required in the lead up to and on 1 July 2022, when CCGs will cease to exist and ICBs will be formally established.

This guidance brings together and supersedes previously published preparatory documents, including the Interim Guidance on Functions and Governance of the ICB, the draft ICB model constitution with supporting notes and draft guidance on application of partner member regulations.

Action required of CCGs

CCGs, working with the designate leaders of ICBs, have been preparing ICB draft constitutions and supporting governance documents, ready to implement the Act.

NHS England has been supporting them in this work, including by sharing preparatory documents which were last updated on 31 March 2022.

In line with CCGs' duties under the Act to propose the ICB constitution for their ICB's area, CCG leads, working with ICB designate leaders, should now:

- **read this guidance, which confirms the policy positions set out in the preparatory guidance of 31 March to check understanding**
- **discuss any outstanding queries regarding the interpretation or application of this guidance with their regional team.**

¹ In this guidance NHS England refers to the NHS Commissioning Board until it is formally merged with Monitor and the NHS Trust Development Authority to be renamed under legislation as NHS England.

Contents

About this document	1
Action required of CCGs.....	1
Executive summary	3
Introduction.....	4
Integrated care systems	4
Integrated care boards	5
Integrated care partnerships.....	5
The process for establishing ICBs.....	6
Preparation of the ICB constitutions	6
Proposal and approval of constitutions	7
Preparation of supporting documents	8
Enabling understanding of governance arrangements.....	9
Bringing ICB governance into effect on 1 July 2022.....	11
ICB board and committees	12
ICB board.....	12
Equality, diversity and inclusion	13
Health inequalities	14
Types of ICB board member.....	15
Membership of the ICB board.....	16
Requirements of specific ICB board members.....	17
Appointment of partner members	18
Conflicts of interest.....	21
Executive responsibilities.....	25
ICB committees	26
New delegation and joint working freedoms.....	28
Joint appointments	29
Those eligible to nominate partner members	31
Role of nominating organisations.....	33
Role of the relevant CCG(s), with designate ICB leaders, in identifying nominating organisations	34
Trust partner members	35
Forward plan condition	36
Level of services provided condition	40
Primary medical services partner members.....	43

Summary

The Health and Care Act 2022 (the Act) requires clinical commissioning groups (CCGs) to prepare the integrated care board (ICB) constitution for their ICB's area and propose it to NHS England for approval. CCGs are expected to do this with the relevant ICB designate leaders. This document, including the annexed template model constitution, is the statutory guidance to which CCGs must have regard in doing so.

It is NHS England's responsibility to publish the ICB areas, which will confirm the CCG(s) in each ICB's area.

Before formally proposing the constitution to NHS England, the CCG(s) must consult on the draft constitution "any persons they consider it appropriate to consult". As a minimum, the CCG(s) must consult relevant NHS trusts/foundation trusts, primary care representatives, local Healthwatch and relevant local authorities. CCGs are expected to include with the formal submission of the constitution to NHS England a list of those that have been consulted, a summary of any consultation responses and how responses have been considered.

NHS England plans to publish the approved ICB constitutions on its website in June 2022. The ICB establishment order will provide for the ICB constitutions by referring to a published document where they are set out. The constitutions will take effect from 1 July 2022. The Act provides, if necessary, for NHS England to determine a constitution if the proposal is inappropriate or the CCG(s) has not carried out appropriate consultation.

To support CCGs prepare the ICB constitutions, NHS England has provided an ICB model constitution with supporting notes. The model constitution clearly shows where text is mandated to ensure compliance with legal or policy requirements – which should not be altered without the agreement of NHS England – and where text is provided as an example that may be amended locally.

This guidance consolidates and supersedes preparatory documents, including previous iterations of the model constitution with notes, the Interim Guidance on Functions and Governance of the ICB and FAQs, and the draft guidance on the ICB partner member regulations. This final guidance to CCGs makes no substantive changes to the 31 March 2022 versions of those preparatory documents.

Introduction

Integrated care systems

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**.

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.

Following several years of locally-led development, Parliament has now passed the Health and Care Act, which will create statutory ICSs in every part of the country, as recommended by NHS England. This will include the establishment of integrated care boards (ICBs) and integrated care partnerships (ICPs).

Integrated care boards

ICBs will take on the functions currently performed by CCGs. Each CCG's staff, assets and liabilities will be transferred to the relevant ICB, and some of NHS England's direct commissioning functions will be delegated to ICBs.

ICBs will bring the NHS together locally to deliver shared priorities, with a greater emphasis on collaboration and shared responsibility for the health of the local population. 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.

Integrated care partnerships

The ICP is a joint committee of the ICB and the upper tier² local authorities that are wholly or partly in the ICB area. From 1 July, the ICB and the local authorities will be under a legal duty to establish the ICP.

It is the role of the ICP to develop and publish the integrated care strategy for the ICB area, in particular focusing on how health and care can better integrate.

Under the Act, it is for the Secretary of State – rather than NHS England – to issue guidance on the integrated care strategy, which they expect to do. The Department of Health and Social Care (DHSC) has published ICP engagement and post-engagement [documents](#) and [frequently asked questions](#).

² For the purposes of this guidance the term 'upper tier local authorities' has the same meaning as the definition of "local authority" used in s.2B(5) National Health Service Act 2006.

The process for establishing ICBs

Preparation of the ICB constitutions

The Health and Care Act states that the CCG(s) must propose the constitution for the first ICB to be established for the ICB area. CCGs are expected to develop the constitution with the ICB designate leaders.

To support this NHS England has produced an ICB model constitution with notes attached as an annex. It has mandated elements (legal or policy requirements) shown in black text, and elements that may be modified locally where green text shows example wording.

The Act requires that CCGs “must consult any persons they consider it appropriate to consult” on the constitution, and that this may be done before the legislation comes into effect.

As a minimum CCGs should consult the following bodies/organisations:

- relevant NHS trusts/foundation trusts
- primary care representatives
- local Healthwatch
- relevant local authorities.

When submitting proposed ICB constitutions to NHS England for approval, CCGs should also submit a list of those they have consulted on proposed constitutions, a summary of any consultation response and how responses have been considered and taken into account.

Proposal and approval of constitutions

Where there is one CCG in the ICB area, the governing body must make a formal decision to propose its ICB constitution to NHS England.

Where there is more than one CCG in the ICB area, the relevant CCGs must jointly propose the constitution. There are a variety of ways CCGs could make a decision together to propose the ICB constitution to NHS England. For example, the governing bodies could³:

- separately agree the same draft
- hold a meeting at which they are all present (governing bodies meeting in common)
- each (subject to their constitutions) delegates to a senior officer, and the respective senior officers agree, or
- set up a committee in common arrangement.

Once the decision to propose the constitution has been made,⁴ the CCG accountable officer(s) should formally communicate this decision and their proposed ICB constitution to the NHS England Regional Director.

The NHS England Regional Director will recommend to the NHS England Chief Executive whether the proposed constitution should be approved. The model constitution allows for NHS England to attach conditions to its approval; for example, where it is recognised that proposals may be appropriate initially but will need to be revisited as committees of the ICB – including place committees – are ready to take on greater responsibility.

The Act provides, if necessary, for NHS England to determine a constitution if the proposal is inappropriate or the CCG(s) have not carried out appropriate consultation.

³ Note that as the function is not a 'commissioning function' they cannot use the s14Z3 powers to exercise functions jointly and establish a formal joint committee.

⁴ It is unlikely that a CCG constitution (including standing orders) would require the approval of the member practices before proposing the ICB constitution to NHS England (it is not an amendment to the CCG constitution). However, if this is the case, this should be done before making the decision – engaging NHS England if this presents particular challenges.

The first constitution of the ICB will be given effect by NHS England and the establishment order will provide for the ICB constitutions by referring to a published document where they are set out. There is no requirement for the first meeting of the board⁵ to approve the constitution, though it will be important to ensure that all board members are familiar with the constitution and the provisions within it.

Preparation of supporting documents

CCGs will also need to prepare a number of supporting documents in addition to ICB constitutions, as follows.

To be appended to the constitution:

- **Standing orders** – to set out the arrangements and procedures to be used for meetings and the processes to appoint to ICB committees.

Documents⁶ that do not form part of the constitution but will be required to be published include:

- **Scheme of reservation and delegation (SoRD)** – 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, and (iii) functions delegated to another body or to be exercised jointly with another body.
- **Functions and decision map** – a high level diagram to help stakeholders understand where decisions are made (eg where delegated to place committees). It should:
 - be locally defined
 - set out where decisions are taken and outline the roles of different committees/partnerships
 - be easily understood by the public.
- **Standing financial instructions** – set out the arrangements for managing the ICB's financial affairs.

⁵ In this document 'board' refers to the chair, chief executive and ordinary members who together constitute the body corporate; 'ICB' is used to refer to the organisation.

⁶ The Act does not make these documents, unlike the constitution, subject to NHS England approval. The documents must be prepared in advance of 1 July 2022, in accordance with the Readiness to Operate process. A resolution of the ICB board will bring the documents into effect.

- **Key policy and other documents** – including terms of reference for all committees and sub-committees that exercise ICB functions; the ICB’s conflicts of interest policy, procedures and register; standards of business conduct policy; policy for public involvement and engagement.

ICBs will need a seal if they anticipate entering into any land transactions that are required to be executed under seal. The standing orders of the ICB model constitution include a section on use of the seal in which arrangements for its safe keeping and authorisation of use can be set out.

Enabling understanding of governance arrangements

The constitution with the supplementary documents must be presented as a single easily navigable whole on the ICB website to support transparency and engagement. This full set of documents – with an introduction and any other documents determined locally – is referred to as the ICB ‘governance handbook’.

The introduction to the governance handbook should make it clear to a general reader how they can inform decision-making, including by understanding who makes decisions (functions and decisions map), how they can find out what matters are being considered, how they can influence them and the role of the local Healthwatch.

The ICS implementation guidance for working with [people and communities](#) describes considerations that ICBs should give to involvement of people and communities in ICB governance.

It guides systems to define, adequately resource and support the role of members of the public in governance arrangements. Therefore, the ICB governance documents (including in the governance handbook) should make clear how delivery of the people and community engagement strategy will be assured, including:

- How the board has strategic oversight and assurance of involvement of people and communities in the exercise of its functions.
- Responsibility to respond to community feedback and priorities identified through the engagement strategy in timely and accessible ways.
- Arrangements to work with and alongside local partners such as Healthwatch and voluntary, community and social enterprise (VCSE) partners. An explanation of how the VCSE alliance will inform the ICB should be included in

the ICB's governance handbook. (System leaders should work with their VCSE alliance to agree how the alliance will inform the ICB's planning and decision-making, including understanding of the VCSE provider landscape.)

- How the board and its committees will consider the diversity of the population, including those who experience the greatest health inequalities, and how they have been involved in decision-making (including delegated decisions). The latter includes through formal collaboration with local Healthwatch to ensure that its statutory functions are considered and how people's voices and experiences across providers and partners are co-ordinated and heard.
- Set out how decision-making and governance will be transparent to the wider public (eg published papers, meetings in public, direct community engagement).

The ICB's strategy for working with people and communities should be easy to find in the handbook; and it should be clearly explained how the board has strategic oversight and assurance of involvement of people and communities in the exercise of its functions, with an assessment in the ICB's annual report of how this is being discharged.

The ICB website should include up-to date information on board meetings and members, including a register of interests. It should also give details of how to get involved in the ICB, for example by:

- attending public board meetings and asking questions
- submitting complaints and comments
- submitting Freedom of Information requests
- contacting local Healthwatch, with links provided
- other ways to get involved, as detailed.

In addition, in July 2022 NHS England will update the current [statutory guidance on involving people and communities \(patient and public participation\)](#) to reflect ICBs succeeding CCGs.

The ICB will need to ensure transparency, as the Act requires, and to decide which meetings should be held in public to achieve this. The ICB will be subject to the Public Bodies (Admission to Meetings) Act 1960, which has several associated requirements that ICB governance leads will wish to familiarise themselves with. The legal

requirements apply to board meetings or committees at which all board members are present, or which are made up of board members only.

A body/committee that usually meets in public may, if it passes a resolution, exclude the public from all or part of a meeting if the item is of a confidential nature or for other special reasons stated in the resolution. There is no expectation that remuneration or audit committees are held in public.

The Freedom of Information Act requires every public authority to have a publication scheme, approved by the Information Commissioner's Office (ICO), and to publish information covered by the scheme. The ICO publishes [a model publication scheme](#) that sets out the minimum information that every public authority, including ICBs, should publish. It has also produced a [definition document for health bodies in England](#) that gives examples of the kinds of information the ICO expects organisations to provide to meet their commitments under the model publication scheme. The ICB model constitution references the following documents in particular: register of interests; board papers and minutes of all meetings held in public; audited annual accounts; complaints process; the annual report; the five-year joint forward plan.

Bringing ICB governance into effect on 1 July 2022

The establishment order made by NHS England will take effect and bring the ICB into being at midnight at the beginning of 1 July 2022; CCGs will be dissolved at the same time (this will happen automatically under the legislation, with no further steps needed). The chair's substantive appointment will also take effect at this time. The chair should then appoint the chief executive into their role (with NHS England approval).

A committee consisting of the chair, chief executive and one other (eg an HR professional) should appoint all the designate ordinary members (non-executive, executive, partner and any 'other' ordinary members) into their roles on a substantive basis. Section 3.15 in the model constitution covers first appointments and allows for this.

The first board meeting should be held – NHS England will have brought into effect the constitution with standing orders through the establishment order – and the following business transacted:

- agree standing financial instructions

- agree SoRD (and functions and decisions map)
- establish committees, appoint the chairs of committees and agree the terms of reference. Appoint the memberships of ICB committees (as a minimum this must include the remuneration committee, others could potentially wait)
- adopt suite of policies, including at least all those mentioned in the constitution and any that statutory bodies are required to have in place
- appoint to special/lead roles on the board (eg conflicts of interest guardian)
- appoint the ICB founder member of the ICP.

The remuneration committee should meet on the same day to agree the remuneration of all board members. Although in principle it should be possible for the recommended remuneration (agreed on appointment as designates) to be revised, in practice it should simply be a case of approving the pay recommended by the process undertaken before ICB establishment. If the constitution sets out that non-executive pay is not agreed by the remuneration committee, then whatever mechanism is used must be employed.

ICB board and committees

ICB board

The ICB will have a unitary board, which means all its members are collectively and corporately accountable for the organisational performance of the ICB, a statutory body charged with specific legal functions. They will also need to promote the NHS Constitution and meet the triple aim.⁷

Systems have been supported to make designate ICB board appointments but there is no requirement from NHS England to set up a shadow ICB board or shadow ICP. CCGs are required to consult designate ICB leaders on significant decisions.

While preparations for these new arrangements are being made, all NHS organisations must continue to operate within the current legislative framework,

⁷ The triple aim is: 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.

retaining any governance mechanisms necessary to maintain operational delivery (including patient safety, quality and financial performance).

As the ICBs have yet to be established and so do not currently have any legal status or powers, there is no requirement for meetings of ICB board member designates to take place in public. However, consideration should be given to the benefits of meeting in public in demonstrating the ICB intention to operate openly and involve people and communities in meaningful ways.

Equality, diversity and inclusion

The development and implementation of effective equality, diversity and inclusion (EDI) strategies will lead to advances in equality, improved health delivery and greater staff and patient experiences of the NHS.⁸ The ICB board is expected to show leadership in advancing EDI, including by ensuring that:

- the workforce (at all levels) represents the diversity of the NHS
- people working and learning in the ICB 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 discrimination, advancing equality of opportunity, fostering good relations, health inequalities, and addressing overlap between workforce and wider population inequalities
- there is an organisational culture that promotes inclusion and embraces diversity and equality
- members of the unitary board and employees display the highest standards of inclusive behaviour and adhere to the competencies expected of them
- they are utilising data to improve performance of organisations, including use of the NHS Workforce Race Equality Standard (WRES) and any future information and equality standards as a key performance indicator.⁹

⁸ 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.

⁹ It is expected that the NHS WRES will be extended to ICBs following consultation during 2022/23.

ICBs will be subject to section 149 of the Equality Act 2010 (the Public Sector Equality Duty) and the specific equality duties as well as the wider provisions in the Equality Act 2010. In accordance with this Act, ICBs will need to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- foster good relations between person who share a relevant protected characteristic and persons who do not share it.

Further guidance on the Public Sector Equality Duty will be published in due course. ICBs should be mindful of the [technical guidance](#) on the Public Sector Equality Duty and the relevant [statutory codes of practice](#), published by the Equality and Human Rights Commission.

Health inequalities

CCGs and ICB designate leaders should be mindful that the Health and Care Act 2022 will introduce a range of ICB obligations in relation to health inequalities, which should underpin the discharge of functions in each ICB, including:

- A new duty on health inequalities for ICBs, changing the previous duty on CCGs. The new health inequalities duty is: “Each integrated care board must, in the exercise of its functions, have regard to the need to – (a) reduce inequalities between persons with respect to their ability to access health services, and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services”.
- A new quality of service duty on ICBs which includes addressing health inequalities.
- A duty to promote integration where this would reduce inequalities in access to services or outcomes achieved.
- Duties on ICBs in relation to several other areas that require consideration of health inequalities – in making wider decisions, planning, performance reporting, publishing certain reports and plans, annual reports and forward planning.

In addition, each ICB will be subject to an annual assessment of its performance by NHS England, which will assess how well the ICB has discharged its functions in relation to a range of matters including reducing health inequalities, improving quality of service, and public involvement and consultation.

Types of ICB board member

The Act requires the board to consist of the chair, chief executive and “ordinary members”. All ordinary members of the board have equal standing and all are appointed by the ICB. NHS England and the model constitution use the following terms to identify different types of ordinary member and these terms must not be departed from in ICB constitutions:

- ‘Partner members’: only board members who are jointly nominated in accordance with the Act and the relevant secondary legislation (regulations) by the relevant local authorities, trusts/foundation trusts or primary medical services providers.
- ‘Non-executive members’: only members who bring a perspective independent of local health and care organisations.
- ‘Executive members’: only those senior executive employees of the board who have ex-officio board positions.
- ‘Other members’: any other ordinary members of the board who are not partner members, non-executive members or executive members.

The ICB constitution must set out exactly how many of each type of ordinary member will be on the board and for each position any enduring qualification criteria, such as particular registration, expertise or experience. The description of each position in the constitution will be supplemented by a role description and person specification. Note that – except for executive members who are ICB employees – board positions cannot be in effect ex officio¹⁰ as this is not compatible with the Act’s requirement that the chair decides whether or not to approve the appointment of an ordinary member.

Other individuals may be invited to participate or observe board meetings. The terms that must be used in ICB constitutions for these individuals are as follows.

¹⁰ For example, the constitution, or role profile, cannot state that the person appointed must be the chief executive of a named foundation trust. It could however state that the person must have chief executive level experience of leading a trust/foundation trust.

- ‘Participant’: a person who is invited to participate in the board meeting but is not a member of the board.
- ‘Observer’: a person who is invited to observe the board meeting, typically receiving the public board papers and so differentiated from any member of the public choosing to observe the meeting.

The constitution may identify regular participants and observers. However, the distinction must be clearly maintained in board meetings between board members – who make the decisions and are accountable for them – and participants who do not.

Membership of the ICB board

Every ICB board member must:

- comply with the criteria of the fit and proper person test¹¹
- uphold the Seven Principles of Public Life (known as the Nolan Principles)
- fulfil requirements relating to relevant experience, knowledge, skills and attributes set out in the ICB’s constitution, role descriptions and person specifications
- comply with the disqualification criteria set out in the ICB constitution. A person cannot be appointed to the board if the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate’s involvement with the private healthcare sector or otherwise.

The Act requires the ICB to keep under review the skills, knowledge and experience that it considers board members need to possess (when taken together) for the board effectively to carry out its functions; and to take such steps as it considers necessary to address or mitigate any shortcoming. It is expected that ICBs will want to review their governance arrangements in Q1–Q2 2023/24 in light of the first year of operation, including the further development of place-based arrangements, the ICP and provider collaboratives.

¹¹ The fit and proper persons test is being updated following the [Kark review](#). It is expected that the revised regulations will apply to ICBs. This requires that evidence of compliance will be shared with the relevant authority and a commitment to regular review of continued compliance. Where candidate partner member(s) have already undergone equivalent checks with other statutory bodies, such as local authorities, liaison with the local government monitoring officers to secure the information and assurance will be appropriate. Each case should be taken individually to ensure the assurance is sufficiently recent not to warrant a new test to be undertaken.

Requirements of specific ICB board members

The ICB chair is appointed by NHS England, 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.

There must be a minimum of two non-executive members, one to chair the audit committee and one to chair the remuneration committee. They must not hold roles in other health and care organisations within the ICB area.

The chief executive must be employed by, or seconded to, the ICB. They are appointed by the chair, with the approval of NHS England.

The following executive members must be appointed to the board:

- chief finance officer, who must be employed by, or seconded to, the ICB
- director of nursing, who must be employed by, or seconded to, the ICB. They must be a registered nurse (not a registered midwife only)
- medical director,¹² who must be employed by, or seconded to, the ICB. They must be a registered medical practitioner.

ICB constitutions must include partner members on the board as follows. Note that partner members are not delegates from their constituencies but equal and accountable members of the ICB unitary board.

- At least one member jointly nominated by the eligible NHS trusts and foundation trusts. This partner member is normally expected to be the chief executive of one of those NHS trusts/foundation trusts. They should bring the perspective of the sector, and it will be of benefit for them to additionally engage with other significant providers, notably social enterprises.
- At least one member jointly nominated by the eligible providers of primary medical services. This partner member should bring the perspective of general practice and an understanding of wider primary care, including primary care networks (PCNs), and primary dental, community pharmacy and optometry providers.

¹² The term 'chief medical officer' should only be used with the agreement of NHS England, to avoid confusion with the national role.

- At least one member jointly nominated by the local authorities whose areas coincide with, or include the whole or any part of, the integrated care board's area. This partner member will often be the chief executive of their organisation, or in a relevant executive local authority role; however, they may be a councillor where locally most appropriate.

Where ICBs wish to have more than one member from any of these categories, they may choose to include criteria in the constitution, and role description and person specification, so that the roles are populated by individuals who are able to bring different perspectives to the ICB board¹³. For example, it could be specified that one individual jointly nominated by trusts/foundation trusts should have experience such that they are able to give an informed view about the provision of community services.

The chair must exercise their approval function of the ordinary members with a view to ensuring that at least one of the ordinary members has “knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness”. For the ICB to achieve ongoing compliance with this requirement, the constitution should include a board position that can only be filled by candidates who meet these criteria; this board role may be a partner member¹⁴ (jointly nominated by all trusts/foundation trusts), an “other” board member (that is, not jointly nominated but likewise normally a mental health trust/foundation trust chief executive) or an ICB executive director for mental health.

Appointment of partner members

The constitution of the ICB must set out the process for appointing the partner members and those NHS trusts/foundation trusts and local authorities eligible to nominate.¹⁵ As with other board roles, enduring requirements of each of the partner member roles should be set out in the constitution and further detail provided in a role description and person specification.

The Act requires that partner members are to be “nominated jointly” (see next section on identifying those eligible to nominate) by their respective sector, and it requires that

¹³ Where the ICB has more than one partner member in a category and their roles are distinct, candidates should be nominated separately for each position so that nominating organisations can make nominations that have regard to the distinct requirements of each position.

¹⁴ Must be an additional partner member to the one required as a minimum by the Act.

¹⁵ The list of GP providers eligible to nominate will be maintained separately from the constitution, within the governance handbook, to avoid frequent applications to modify the constitution (eg as Alternative Provider Medical Services (APMS) contracts come to an end).

the ICB chair decides whether to approve the appointment of each ordinary board member, including partner members. NHS England expects that all board members – including partner members – are 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 ICB constitution, role description and person specification.

Therefore, the appointment process for partner members must consist of joint nomination, assessment and selection, and approval stages.

Within these parameters the process may be determined locally. At the request of systems, the draft model constitution includes suggested text (not mandated) for a compliant process as follows.

Joint nomination

- ICBs need to ensure that their nomination processes fulfil the requirements of being ‘jointly nominated’. Before the joint nomination begins, the CCG/ICB would circulate not only the list of eligible organisations and the enduring requirements of the role stated in the constitution itself but also the role description and person specification.
- Nominations would be ‘joint’ if the nominating organisations can achieve full consensus on one or more nominees – this may be possible among trusts/foundation trusts and among local authorities, but it is unlikely to be practicable when there are large numbers of organisations involved (eg general practices).
- To be ‘joint’ it is not necessary for the nominating organisations to achieve full consensus on who should be nominated; for example, it would be ‘joint’ if the nominating organisations approve, by majority, a list of individuals to be nominated. In such an approach it is recommended that failure to respond is taken as assent to the list going forward to the ICB so that if any eligible organisations do not respond, this does not delay the process. Rejection or agreement should apply to the whole list rather than a single nomination. The use of elections to identify nominees individually is very unlikely to be compatible with the requirement to achieve a well-balanced board as a whole and may result in eligible organisations in the minority being marginalised.

- ICBs could choose to add a requirement in the constitution that individuals proposed for nomination should be seconded from a sufficient number of nominating organisations. This may be prudent if there is the prospect of a very large number of nominees.

Assessment, selection and appointment subject to approval

- All board roles should have a role description and person specification. All board members should be assessed to ensure they meet the fit and proper persons test, the requirements of the role and other eligibility criteria in the constitution. The ICB should convene a panel to undertake this assessment and, where there is more than one suitable candidate, they should select the best, agreeing their appointment subject to the chair's approval. The constitution will need to specify who makes the appointment. Please note the proposed specific arrangements for the appointment of ordinary members made **at establishment** is at clause 3.15 of the model constitution.
- This assessment and selection process will provide assurance to the chair that the proposed appointee meets the full range of requirements for the role, is not disqualified from ICB membership and, if relevant, is the most suitable candidate or nominee. It is not appropriate for the board to outsource or delegate the assessment and selection process to an external party, such as a local authority, local medical committee, provider collaborative or primary care network. While these organisations should not run or be the decision-makers in relation to the assessment and selection process, ICBs could, if they felt it appropriate, invite individuals from these organisations to provide advice on, or observe, the process.

Approval by the chair

It is a legal requirement for the chair to approve (and potentially reject) the proposed appointment of every ordinary board member.

At each of the above three stages, the relevant decision-makers should take into account the ICB's duty to keep under review the skills, knowledge and experience that it considers necessary for board members to possess (when taken together) for the board to carry out its functions effectively – board positions should be filled with this in mind.

All recruitment processes must comply with the requirements of the Equality Act 2010 and the board should also be mindful of relevant guidance published by EHRC.¹⁶

Conflicts of interest

The Act addresses ICB duties on conflicts of interest. Each ICB must set out in its constitution:

- The arrangements for managing conflicts and potential conflicts of interest in such a way as to ensure that they do not, and do not appear to, affect the integrity of the board's decision-making processes.
- The process by which any appointment of a member to the board or any appointment to any committee or sub-committee of the board that has a commissioning function must be made so as to avoid the appointment of anyone who would be perceived to have a conflict or a potential conflict of interest.
- The arrangements for ensuring that no member of any committee or sub-committee of the board who has a conflict or a potential conflict of interest obtains access to information that might be perceived to favour the interest or potential interest.
- That a person is disqualified from board membership if they could reasonably be regarded as undermining the independence of the health service because of their involvement with the private healthcare sector or otherwise.
- That the chair approves or appoints the members of any committee or sub-committee exercising commissioning functions; and the ICB must prohibit the chair from approving or appointing someone as a member of any such committee or sub-committee if the chair considers that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

In addition, the Act requires each ICB to maintain, and publish/make available to the public, one or more registers of the interests of board members, members of its committees or sub-committees, and its employees; and that the ICB ensures:

¹⁶ [Appointments to boards and equality law](#)

- those individuals declare any conflict or potential conflict of interest they have in relation to a decision to be made in the exercise of the commissioning functions of the ICB
- those individuals make any such declaration as soon as practicable after the person becomes aware of the conflict or potential conflict and, in any event, within 28 days of the person becoming aware
- the declaration is included in the registers maintained.

Further, the Act requires that each ICB constitution must include:

- provision about the arrangements to be made by the ICB for discharging the above requirements
- a statement of the principles to be followed by the board in implementing those arrangements.

The guiding principle for conflicts of interest policy is to ensure that decisions are made in the public interest by avoiding any undue influence. The definition of a conflict of interest, based on current NHS guidance, is:

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 principles of collaboration, transparency and subsidiarity should be at the centre of any decision-making. The Act takes account of these principles and bases governance structures around them. It should not be assumed that the board will always be conflicted because at least three of its members must be jointly nominated (the 'partner members'). It is crucial that ICBs ensure that the board and committees are appropriately composed and take into account the different perspectives individuals will bring from their respective sectors to inform decision-making.

Partner board members (or 'other' ordinary board members but not non-executive members) may have duties and responsibilities that relate to a role they have with another body in the ICS. These individuals will need to satisfy themselves that the duties, responsibilities and accountabilities of their two roles do not conflict and that the constitution or memorandum/articles of association of both organisation in which

they have a role do not create any barriers to them fulfilling the requirements of both roles.

NHS England does not plan to issue conflicts of interest guidance specifically for ICBs – as was done for CCGs – but rather sets out the principles below. If dialogue with ICB chairs and other stakeholders during 2022/23 indicates that detailed NHS England guidance would be helpful, then such conflicts of interest guidance specifically for ICBs may be developed. However, the NHS-wide guidance, [Managing conflicts of interest in the NHS: Guidance for staff and organisations](#), will be updated to make clear it also applies to ICBs.

NHS England recommends the following principles for ICBs.

1. Decision-making must be geared towards meeting the statutory duties of ICBs at all times, including the triple aim.¹⁷ 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.
2. ICBs have been created to give trust/foundation trust, local authority, and primary medical services (general practice) provider nominees a role in decision-making. These individuals will be expected to act in accordance with the first principle, and while 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 possibility of actual and perceived conflicts of interests arising will remain. For all decisions, ICBs will need to carefully consider whether an individual's role in another organisation could result in actual or perceived conflicts of interest and whether or not these outweigh the value of the knowledge they bring to the process.
3. 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

¹⁷ The triple aim is a 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.

as soon as practicable after the person becomes aware of the conflict or potential conflict and, in any event, within 28 days of them 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.

4. If an interest is declared but there is no risk of a conflict arising, then no further action need be taken (although the interest will still need to be recorded). However, if a material interest is declared, then it should be considered to what extent it affects the balance of the discussion and decision-making process. In doing so the ICB should ensure conflicts of interest (and **potential** conflicts of interest) do not, and do not **appear** to, affect the integrity of the ICB's decision-making processes.
5. ICBs should consider the composition of decision-making forums and clearly distinguish between those individuals who should be involved in formal decision-taking and those whose input informs decisions. In particular, ICBs should consider the perspective the individual brings and the value they add to both discussions around particular decisions and in actually taking part in the decision, including the ability to shape the ICB's understanding of how best to meet patients' needs and deliver care for their populations. The way conflicts of interest 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 ICB to involve them in discussions, eg 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.
6. Actions to mitigate conflicts of interest 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 perception of any conflicts and how a decision may be received if an individual with a perceived conflict is involved in that decision, and the risks and benefits of having a particular individual involved in making the decision. Potential options in relation to mitigation could include:
 - a. including a conflicted person in the discussion but not in decision-making

- b. excluding a conflicted person from both the discussion and the decision-making
 - c. including a conflicted person in the discussion and decision where there is a clear benefit to them being included in both – however, including the conflicted person in the actual decision should be done after careful consideration of the risk and with proper mitigation in place. The rationale for inclusion should also be properly documented and included in minutes
 - d. excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
7. The way conflicts of interest are declared and managed should contribute to a culture of transparency about how decisions are made. In particular, when adopting a specific approach to mitigate any conflicts of interest (including perceived conflicts), ICBs should ensure that the reason for the chosen action is documented in minutes or records.
8. These factors should be read in conjunction with other relevant NHS England statutory guidance, including guidance when published on the provider selection regime and guidance on joint working and delegation arrangements. In relation to the provider selection regime, 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. (Note: the secondary legislation that will establish the new procurement rules must address the management of conflicts of interest.)

Executive responsibilities

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.

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

During the consideration of the legislation, parliamentarians made clear that they wanted to see clearer executive leadership on certain issues. The government and NHS England agreed that ICBs will be required to identify named executive board member leads for safeguarding and special educational needs and disabilities (SEND), and for children and young people's services. These are not new statutory duties or additional board posts, but rather intended to secure visible board-level leadership of these issues.¹⁸

ICB committees

ICBs must ensure they can effectively discharge their full range of functions. This is likely to include establishing committees¹⁹ of the ICB to support the board and exercise any delegated functions. The Act gives significant flexibility on the membership of ICB committees and sub-committees, allowing individuals to be appointed who are neither ICB board members nor employees.

Boards will be supported by an executive group including, for example, other professional and functional leads, to manage the day-to-day running of the organisation. Individual directors of the ICB may be given delegated authority, which they may choose to exercise through a committee with the approval of the board.

Which committees the ICB board chooses to establish will depend on decisions taken locally about how the functions will be exercised and how assurance will be generated and reported. However, all ICBs are expected to establish as a minimum remuneration, audit and quality committees.

- The remuneration 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. It will be

¹⁸ NHS England may issue separate guidance on meeting this commitment.

¹⁹

- Committees are established by the board for the purpose of exercising ICB functions that the board chooses to delegate, providing assurance or formal advice to the board. The detailed arrangements for committees will be set out in the SoRD, the standing orders and the committee's terms of reference.
- With the agreement of the board a committee may establish sub-committees to assist with its responsibilities.
- The board may establish advisory groups and task and finish groups that have no decision-making powers but may provide advice, propose solutions and recommendations.
- The ICB will have the power to establish joint committees with certain other organisations to exercise its or the other body's/bodies' functions jointly.

chaired by a non-executive board member other than the chair or the chair of the audit committee; but non-executive members must recuse themselves where the committee has been charged with determining the remuneration of non-executive members. It may make decisions itself, rather than only making recommendations to the ICB board. The remuneration of executives and non-executives will be determined within national pay frameworks. Note that the legislation allows for the partner or 'other' ordinary members to be remunerated where relevant; what is appropriate may vary for different members, depending on their circumstances. No members should be paid twice for the same time by different organisations.

- The audit 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. It will be chaired by a non-executive board member who has qualifications, expertise or experience that enables them to express credible opinions on finance and audit matters.
- The ICB may choose to delegate responsibility for providing assurance on the quality of services commissioned to a quality committee, which may be combined with other assurance responsibilities, eg performance/finance. However, such a committee must be separate from the system quality group (SQG), although the SQG will be chaired by the ICB executive director with responsibility for quality (eg medical director, director of nursing) – see the [NQB guidance](#) for further information. This separation is necessary because they have different remits, membership and lines of accountability (quality committees are an internal quality assurance mechanism for ICBs to ensure they are effectively discharging their statutory duties; SQGs are for intelligence sharing, engagement and improvement across system partners, including regulators). The roles and responsibilities of ICBs regarding management of quality risks will be confirmed in formal agreements with NHS England regional teams. This will include a defined governance, risk and response process for quality, which ensures that risks are managed in a timely and proactive way.

Particular regard will need to be given to the role of committees in discharging functions and duties relating to finance, performance, workforce/people, digital, transformation, transitions and place.

It should be noted that where the ICB board decides to establish committees at place level to exercise delegated commissioning functions,²⁰ these may be supplemented by consultative forums including a wider membership (a health and wellbeing board could take this role, as could a task and finish group of the ICP) to inform the decision-making of the ICB and potentially local authorities. How key parties contribute at place level will be for local determination, including: 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; and the VCSE sector.

New delegation and joint working freedoms

The Act allows an ICB to delegate any of its functions to be exercised by, or jointly with, one or more ICBs, an NHS trust, a foundation trust, NHS England, a local authority, a combined authority²¹ or any other public body that may be prescribed in secondary legislation.

Where an ICB has delegated any of its functions to be exercised jointly with another such body/bodies, the ICB and the other body/bodies may arrange for the delegated function(s) to be exercised by a joint committee and/or the establishment of a pooled fund, to fund those functions. Joint committees will need to be supported by a formal agreement that sets out the terms of any delegation from the ICB to the joint arrangement, including any conditions relating to the exercise of delegated functions.

The secondary legislation is expected to impose a number of restrictions on functions that cannot be so delegated, or make their delegation subject to certain conditions. In addition, the Act gives NHS England the power from 1 July 2022 to issue statutory guidance on the exercise of these freedoms.

It is not expected that CCGs will propose – or ICBs will undertake – such delegation in 2022/23, considering:

²⁰ Contracts would be awarded and held, and payments made, by the ICB as the legal entity.

²¹ Note that the Act allows those NHS bodies to delegate their functions to one another or to local authorities or combined authorities. It does not allow local authorities or combined authorities to delegate their functions to be exercised by NHS bodies.

- the secondary legislation will not be approved until shortly before the establishment of ICBs
- the statutory guidance from NHS England will not be confirmed until July 2022 at the earliest
- the time needed for preparatory work to satisfy the ICB board that it is the right option and transition plans are sound – the ICB would continue to be held to account for the way the function has been discharged
- the Act allows partners to become members of ICBs committees, allowing confidence to be built before moving to more permanent arrangements
- NHS–local authority section 75 partnership provisions are unaffected and may be extended.

This expectation applies only to a formal delegation of ICB functions to NHS providers, local authorities or combined authorities. It does not apply to existing models in which NHS providers take on greater responsibility for designing services, such as the lead provider contracting models used by NHS-led mental health, learning disability and autism provider collaboratives. There also may be circumstances during the course of 2022/23 where NHS England would seek to work with ICBs and providers to support and begin testing delegation arrangements to yield useful learning that will help inform future iterations of statutory guidance or other support resources.

Joint appointments

A joint appointment does not by itself create an arrangement of the joint exercise of functions between two or more NHS bodies. For example, an individual may be appointed to the role of director of finance for two foundation trusts. This does not mean by default that all decisions made by that individual are binding on both organisations. The default position is instead that the joint appointee will take separate decisions for each of the organisations. It is only where the organisations choose to combine a joint appointment with an arrangement for the joint exercise of their functions, with the joint appointee taking decisions as part of that arrangement, that they will have authority to take single decisions binding on both organisations.

Neither the NHS Act 2006 nor the Health and Care Act contain express provisions either permitting or preventing joint appointments. However, the Health and Care Act contains a provision that NHS England may issue guidance about joint appointments between NHS England, ICBs and NHS trusts/foundation trusts; and between NHS

organisations and local and combined authorities. Whether NHS England should issue such guidance is currently under consideration.

Organisations will need to check their individual governance arrangements for restrictions specific to their circumstances. For example, the ICB model constitution prevents the chair from holding a role in another health and care organisation within the ICB area and the chief executive may not hold any other employment or executive role.

Joint appointments risk that the duties, interests and priorities of the different organisations could on occasion be opposed or in conflict with one another. All conflicts of interest must be identified and actively managed in line with each organisation's governance. All joint appointments must also consider the Seven Principles of Public Life (the Nolan Principles) which outline the ethical standards those working in the public sector are expected to adhere to. Consideration of the following questions acts as a framework to support organisations in testing the suitability and practicability of a joint appointment in their circumstances:

- a. What expertise is required for the role?
- b. Would an individual have the capacity to undertake both roles?
- c. What is the cost/benefit analysis for the joint appointment (including qualitative and quantitative benefits)?
- d. When carrying out their (multiple) roles, could the person find themselves in a situation where the duties, interests and priorities of the two organisations are opposed or in conflict with one another?

It is essential that both actual and potential conflicts, or the appearance that there may be a conflict, are transparently and effectively managed, such that all stakeholders can have confidence in the rigour and objectivity of decision-making processes. The guiding principle for NHS organisations is to ensure that decisions are made in the public interest, avoiding any undue influence by other interests. An assessment of the potential for conflicting duties being placed on an individual, and making arrangements to manage them, does not imply that there are concerns any individual will act improperly. This reflects good governance, and part of the value of such arrangements is that they can protect individuals from unjustified accusations that they have acted improperly.

Those eligible to nominate partner members

The government will set out secondary legislation (regulations) determining which trusts and which primary medical services providers may participate in the process for nominating at least one 'ordinary member' for appointment to the ICB board. This section outlines how NHS England expects those regulations to be applied (subject to the legislation), including:

- identification of NHS trusts/foundation trusts that are eligible to jointly nominate the trust board member(s) of the ICB board
- identification of general practices that are eligible to jointly nominate the primary care board member(s) of the ICB board.

For the purpose of this section:

- the term 'trust' refers to NHS trusts and foundation trusts
- the term 'regulations' or 'partner member regulations' refers to the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022.

Nominating trusts and general practices

Nominating trusts

- Trusts will be eligible to jointly nominate the trust partner member(s) of the ICB board if:
 - they provide services for the purposes of the health service within the ICB's area (as per primary legislation), and
 - the relevant CCG and designate ICB leaders consider them to be essential to the development and delivery of the five-year joint forward plan (**forward plan condition**, as described in regulations).
- For the first nominations for the ICB, it is expected that partner status is mutually agreed between trusts, relevant CCG(s) and designate ICB leaders.
- Where a trust providing services for the purposes of the health service within the ICB's area does not meet the **forward plan condition** for any future ICB, it

will become a nominating organisation for the future ICB from which the trust receives the largest proportion of its ICB income for the provision of local NHS services (**level of services provided condition**). This requires an assessment of income received by trusts in the full 2020/21 financial year from any CCG for local NHS services that will in future be commissioned by ICBs.

Nominating general practices

- All primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the future ICB will have core responsibility, will be eligible to jointly nominate the primary care partner member(s) of the ICB board.

The Health and Care Act requires that trusts and providers of primary medical services provide services “for the purposes of the health service within the integrated care board’s area” to be eligible to take part in the ordinary member nomination process. For the avoidance of doubt, this does not require the services provided by a trust or a provider of primary medical services to be physically located within an ICB’s area. It is sufficient that the services they provide are accessed by patients for whom the relevant ICB is responsible, and those services are being provided for the purposes of the health service within the ICB’s area.

This, for example, allows a trust that has no physical presence inside an ICB’s geographical boundaries to be eligible to nominate the trust ordinary member if its services are accessed by individuals for whom the ICB is responsible (and the trust also qualifies under the **forward plan condition** or the **level of services condition**). The new NHS England rules determining for whom the ICB is responsible are anticipated to have continuity with existing rules for CCGs, meaning GP providers would be eligible to nominate only²² for the ICB with which they are associated and which has core responsibility for their registered list.

Nominating local authorities

- Any local authorities responsible for the provision of social care whose areas coincide with, or include the whole or any part of, the future ICB’s area will be eligible to jointly nominate the local authority ICB board partner ordinary

²² GP providers may hold more than one contract with a list conferring eligibility to nominate. Where they have multiple contracts with lists associated with the same ICB, they will be able to nominate as if they held one such contract. Where they hold contracts with lists associated with different ICBs, they will be eligible to nominate to each of those ICBs.

member(s) for that ICB. Eligibility of local authorities to nominate relevant ordinary member(s) is written into the Act and is not subject to regulations.

Process for identifying nominating organisations

- The trusts and local authorities that are eligible to nominate ICB board partner members must be named as such in the ICB constitution. Eligible general practices should be listed in the ICB’s governance handbook (this list will be kept up to date but does not form part of the constitution).

If there is any difference in view between a trust and an ICB on whether they should be a nominating organisation, then this provides an opportunity for NHS England to support the parties to reach agreement before it approves the constitution. It is expected that this will rarely be necessary with ICBs and trusts guided by their shared commitments, including as articulated in the triple aim duty.

Role of nominating organisations

Nominating organisations are eligible to jointly nominate the relevant ICB board partner members. Nominating trusts are also defined as formal “partners” to the ICB in the Act. The legislation outlines further implications of “partner” status for trusts (Table 1) and there may be further implications described in NHS England policy.

Table 1: Roles of nominating organisations defined in the Act

Trusts	Primary medical care providers	Local authorities
<p>Are party to the nomination of the trust ICB board partner member(s)</p> <p>Must develop and agree the ICB’s five-year joint forward plan</p> <p>Must agree the system capital plan</p> <p>May receive grants from the ICB</p> <p>May have its resources apportioned to the ICB for the purposes of statutory financial duties²³</p>	<p>Are party to the nomination of the primary care ICB board partner member(s)</p>	<p>Are party to the nomination of the local authority ICB partner board member(s)</p>

²³ NHS trusts and foundation trusts will have a statutory duty (with ICBs) to ensure their collective use of resources does not exceed an agreed limit. For this purpose, NHS England is able to apportion a trust’s/foundation trust’s resources to one or more of its partner ICBs and intends for 2022/23 to map each trust/foundation trust to one ICB only.

There will be other organisations that are important to engage in collaborative working at system, place or neighbourhood level. However, these are not the ‘nominating organisations’ specifically addressed in this guidance. In some systems, social enterprises are very significant providers, in particular of community services, and it will be important to engage them in the development and agreement of the five-year joint forward plan and on the role of the trust ICB board ordinary member(s). While this is strongly advised, it is not a requirement under the legislation.

Role of the relevant CCG(s), with designate ICB leaders, in identifying nominating organisations

The relevant CCG(s), with designate ICB leaders, should determine if the conditions (‘prescribed description’) set out in regulations for identifying nominating trusts and general practices are met for the period from 1 July 2022 to March 2023. They should also, in line with the primary legislation, identify the relevant local authorities that may nominate ordinary members for the relevant ICB.

Nominating trusts, general practices and local authorities should be identified at an appropriate time to enable timely initiation of nomination processes for designate ICB board partner members. These nomination processes cannot be commenced until NHS England, the relevant CCG(s) and designate ICB leaders have agreed the relevant draft ICB constitution. The constitution must set out:

- the eligible partner trusts
- the eligible local authorities
- the joint nomination, selection and appointment, and approval process for each of the partner members, including the role requirements.

As earlier stated, eligible general practices should be listed in the ICB’s governance handbook (this list will be kept up to date but does not form part of the constitution).

Once this requirement to identify those eligible is met, nominating organisations should be confirmed and designate partner member joint nomination processes initiated.

Until Parliament approves the regulations, there must in principle remain the possibility that the process will have to be re-run. It is expected that Parliament will approve the regulations in May/June and that partner members, and all other ordinary members, will be appointed substantively on 1 July 2022.

Trust partner members

Regulations overview

The Integrated Care Boards (Nomination of Ordinary Members) Regulations are expected to determine that a trust will become a nominating organisation for an ICB if the relevant CCG(s) and designate ICB leaders are satisfied that the trust is essential for the purposes of assisting the ICB in development and delivery of the five-year joint forward plan (**forward plan condition**).²⁴

As a consequence of a trust meeting this condition in respect of an ICB, the trust also falls within the definition of ‘partner trust’ of an ICB for the purposes of the new section 14Z48 of the NHS Act 2006²⁵.

While the regulations set out the ‘prescribed description’ of trust partners, the way in which the **forward plan condition** has been drafted allows for some local discretion in its application.

Where a trust does not meet this condition for any future ICB, it will become a partner to, and nominating organisation for, the future ICB from which the trust receives the largest proportion of its ICB income for the provision of local NHS services (**level of services provided condition**). Application of the **level of services provided condition** prior to establishment of ICBs requires an assessment of income received by trusts in the full 2020/21 financial year from any CCG for local NHS services that will in future be commissioned by each relevant ICB.

Table 2: Rationale for each of the two conditions

Condition	Rationale
Forward plan condition	To enable relevant CCG(s) and designate ICB leaders to identify the relevant partner trusts, guided by whether they are essential to the development and delivery of the five-year joint forward plan, and allowing for local discretion.

²⁴ Note that the wording of regulations refers to whether the ICB is satisfied that the trust is essential to enabling the ICB to exercise its functions in the next five years in relation to delivery of several required elements of the five-year joint forward plan (as described in the Act).

²⁵ Trusts that are nominating organisations are also defined as formal “partners” to the ICB in the Act. This reflects their role in agreeing the five-year joint forward plan and capital plan, and their ability to receive grants from the ICB and be apportioned to it for the purposes of financial control.

Condition	Rationale
Level of services provided condition	To ensure that all trusts are partners to at least one ICB, even if they do not meet the forward plan condition for any future ICB. For example, this could apply to some specialist trusts.

All trusts must be a partner trust in relation to at least one ICB and the application of these rules is expected to result in most trusts being partners to one ICB only. A minority of trusts will be partners to two ICBs (eg those close to ICB borders) and a small number to three or more ICBs.

Forward plan condition

Rationale

The **forward plan condition**, in formal terms, requires that a trust is a partner to an ICB where the relevant CCG(s) and designate ICB leaders are satisfied that the provision of services or arranging the provision of such services by the trust – for the purposes of the health service within the future ICB’s area to persons for whom the ICB is responsible – will be essential for the purposes of enabling the ICB to exercise its functions in the next five years. In other words, the relevant CCG(s) and designate ICB leaders must be satisfied that the trust will be essential for the purposes of assisting in development and delivery of the joint forward plan for the next five years.

For the forward plan condition, the persons for whom an ICB is responsible are persons for whom the ICB has responsibility for the purposes of section 3 or 3A (or both) of the NHS Act 2006.

In particular, the relevant CCG(s) and designate ICB leaders should consider if the trust is essential to development and delivery of at least one of the following duties to be addressed in the five-year joint forward plan as specified in legislation:

- improvement in quality of services
- reducing inequalities
- promoting innovation
- in respect of research
- promoting education and training
- promoting integration

- having regard to wider effect of decisions (triple aim)²⁶
- climate change
- financial duties.

The **forward plan condition** enables relevant CCG(s) and designate ICB leaders to apply some discretion in identification of partner trusts according to local factors.

Application

In determining which trusts are essential to the development and delivery of the five-year joint forward plan, relevant CCG(s) and designate ICB leaders are required in particular to consider:

- The **nature of the services** provided by the trust for the purposes of the health service within the future ICB's area. For example, it may not be appropriate for a provider of specialised, low volume services to the whole population in the future ICB's area to be a partner trust, while it may be appropriate for a trust providing community services to part of the population in the future ICB's area to be a partner although the overall value is lower than for those specialised services.
- The volume of services** provided by the relevant trust for the purposes of the health service within the future ICB's area, including whether it is the **sole, or a main or provider, of services**. For example, where a trust is the only, main or a major provider of services for a specific sector (eg acute, community, mental health or ambulance services), then the relevant CCG(s) and designate ICB leaders may be satisfied that it should be a formal partner to the future ICB. Relevant CCG(s) and designate ICB leaders may also wish to consider the proportion of CCG income the trust/foundation trust receives from the future ICB's area.
- The **nature of any hospitals or other NHS facilities** of, or managed by, pursuant to arrangements made by, the relevant trust at which services are provided to persons to whom the ICB is responsible. For example, if a trust has or manages key NHS hospitals or facilities which provide services for the population within the future ICB's area, relevant CCG(s) and designate ICB

²⁶ The Act requires that, in making a decision about the exercise of its functions, an ICB must have regard to all likely effects of the decision in relation to 1) the health and wellbeing of the population, 2) quality of care and 3) sustainable use of NHS resources.

leaders may be satisfied that will be an important partner to the ICB, even if the great majority of the trust's services are provided to the population within a neighbouring future ICB's area.

If a trust is considered by the relevant CCG(s) and designate ICB leaders to be essential to development and delivery of the joint forward plan in the next five years in respect of any one or more of three considerations above, then it will be a formal partner to the future ICB.

It is generally expected that there will be mutual agreement on trust partner status between relevant CCG(s), designate ICB leaders and trusts. As stated earlier, if there is any difference in view between these parties on whether a specific trust should be a nominating organisation, then this provides an opportunity for NHS England to support them to reach agreement. It is expected that this will rarely be necessary with CCG(s), designate ICB leaders and trusts guided by their shared commitments, including as articulated in the triple aim duty.

Error! Reference source not found. provides examples of scenarios in which trusts would be expected to be formal partners to an ICB under the **forward plan condition**.

Across systems there will be a range of circumstances and local factors. Relevant CCG(s) and designate ICB leaders should apply discretion in considering whether they are satisfied that the nature of a trust's relationship with the future ICB's area means it will be essential for the purposes of assisting the ICB in development and delivery of the joint forward plan, with reference to the three considerations outlined above.

Table 3: Examples of scenarios in which trusts would be expected to be partners to an ICB

Consideration	Examples of trusts expected to be ICB partners
1. Nature of services	<p>Acute, community or mental health trust that provides NHS services for most or all of the population within the future ICB's area.</p> <p>Ambulance trust that provides NHS services for most or all of the population within the future ICB's area.</p> <p>Acute trust that provides NHS community and/or mental health services for all or most of the population within the future ICB's area.</p>

Consideration	Examples of trusts expected to be ICB partners
2. Volume of services, including if the trust is the sole or main provider	<p>Trust that is the sole or main provider of NHS services for the population within the future ICB's area.</p> <p>Trust that is the sole or main provider of NHS services for a specific sector (acute, mental health, community or ambulance) for the population within the future ICB's area.</p> <p>Trust that is a major provider of services for a specific sector (acute, mental health, community or ambulance) for the population within the future ICB's area.</p>
3. Hospitals, establishments and facilities	Trust that has, or manages, hospitals, establishments and facilities that provide services to persons for whom the ICB has responsibility.

Ambulance trusts are important to the strategic planning and integration of care across multiple ICSs, particularly in relation to urgent and emergency care. The relevant CCG(s) and designate ICB leaders should therefore identify their ambulance trust as a formal partner to the relevant ICB.

There may also be circumstances in which a trust will play an important role in arranging provision of services for the relevant future ICB, such as in lead provider arrangements. The **forward plan condition** allows for trusts to be identified as partners where the relevant CCG(s) and designate ICB leaders are satisfied that their role in arranging provision of services will be essential for the purposes of assisting the ICB in development and delivery of the five-year joint forward plan. However, this only applies where the relevant trust will also provide at least some services for the purposes of the health service within the future ICB's area.

Relationship with trust income from ICBs

The income that a trust receives for the provision of services to persons for whom the ICB is responsible is a good indicator of its expected relationship with that ICB, and can be taken into account when considering the volume of services provided. It may therefore be helpful to consider what percentage of its historical CCG income the trust received from provision of NHS services that serve the population for whom a future ICB will be responsible. While there is no threshold value at which a trust should become a partner, analysis indicates that acute, community or mental health trusts with $\geq 10\%$ of their current CCG income received in respect of a single future ICB tend

to be appropriate partners to that future ICBs. However, the applicability of this will depend on local factors.

Where trust income from CCGs is assessed to inform applicability of the **forward plan condition**, NHS England recommends using the approach to calculation described in the **level of services provided condition** below.

Furthermore, the following contextual factors should be taken into account:

- the potential distortion of funding flows and provider income in recent financial years due to COVID-19 financial arrangements
- the forthcoming delegation of certain NHS England-commissioned functions to ICBs, including some specialised services. This is subject to proposals to delegate specialised services to ICBs, which will be confirmed during the course of 2022/23.

Level of services provided condition

Rationale

The **level of services provided condition** requires that where a trust/foundation trust does not meet the **forward plan condition** for any future ICB, it will become a formal partner to the ICB from which the trust receives the largest proportion of its ICB income for the provision of local NHS services. This condition ensures that all trusts are partners to at least one future ICB, based on the future ICB with which they are expected to have the most significant financial relationship.

It is not expected that this condition will be required often. However, it could apply, for example, to specialist trusts, which will provide services across many ICBs.

Application

Application of this condition will, for the first year after ICBs are established, require trusts to calculate the percentage of their historical CCG income for the provision of local NHS services in respect of each relevant ICB. This requires an assessment of income received by trusts in the full 2020/21 financial year from any CCG for NHS services that will in future be commissioned by each ICB. This should be based on the best information available from the most recent full financial year.

This calculation should include income from CCGs only. Any income from other sources, including NHS England, should be excluded from the calculation. Practically, this will likely be based on funds moving from a CCG's financial ledger to a trust's ledger, which is reported in their respective accounts.

NHS trust income is reported through standard accounting, and this enables sources of income to be identified. Providers can calculate what proportion of the income they receive in respect of each future ICB, compared to that received in respect of all future ICBs, by reference to the provider's historical income from the CCGs.

Providers may also receive income from sources other than CCGs for a local population or area, eg income received from NHS England for specialised services and public health. These other sources of income should be excluded from the calculation.

Furthermore, NHS trusts may receive income from other NHS providers through a sub-contract, which relates to a contract that provider holds with a CCG. NHS England would expect this to be added to any income received from the CCG directly for the sub-contractor, and correspondingly subtracted from the sub-contracting trust (eg lead provider), for the purpose of the **level of services provided condition**. On some occasions, the contract might not explicitly identify payment from one CCG that is then funded through to sub-contracts – for example, if there are multiple CCGs contracting collaboratively – and it may not be possible then to include this income in the calculation.

Example application of the level of services provided condition

An NHS trust is not deemed to meet the **forward plan condition** for any future ICB in whose area it provides services. The trust received £200 million in total CCG income in the 2020/21 financial period for provision of NHS services, which in future will be commissioned by seven ICBs. This income can be broken down as follows:

CCG income value	Future ICB
£40m	ICB A
£40m	ICB B
£5m	NHS provider acting as a lead provider for a contract with ICB B
£35m	ICB C
£30m	ICB D
£25m	ICB E
£15m	ICB F
£10m	ICB G

The trust has received:

- a total of £40 million from future ICB A, which equates to 20% of ICB income
- a total of £45 million from future ICB B, which equates to 22.5% of ICB income
- up to £35m for each of the remaining future ICBs, which equates to ≤15% of its income in respect of any one of these.

The trust therefore receives the largest proportion of its CCG income in respect of future **ICB B** and will therefore be a partner to this ICB.

Where distortion of funding flows due to COVID-19 financial arrangements or forthcoming delegation of certain NHS England-commissioned functions alters the outcome when applying this condition, relevant CCG(s) and designate ICB leaders are advised to revisit whether the **forward plan condition** can be applied.

Primary medical services partner members

All primary medical services contract holders responsible for the provision of essential services to a list of registered persons within core hours,²⁷ which includes persons for whom the future ICB will have core responsibility, will be eligible to jointly nominate the primary care partner member(s) of the ICB board.

Eligible nominators will therefore include individuals, partnerships or corporate bodies²⁸ which hold a General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS) contract, where those contracts are for the provision of essential services to a list of registered persons within core hours, which include persons for whom the future ICB will have core responsibility. The regulations specifically exclude trusts that provide such services from this definition.

This continues the current rules used for CCG membership and, as currently, contracts for primary medical services without a patient list, e.g. serving the homeless, would not confer eligibility. As is the case for CCGs, the population of the future ICB will be comprised of these patient lists and therefore there will be alignment.

²⁷ Note that the regulations use the GMS, PMS and APMS contract definitions of 'essential services', 'core hours' and 'registered patients' in this context.

²⁸ For clarity, the nominator will be the contract holder (eg a partnership or company), rather than individual general practitioners or other employees of the contract holder.

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