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NHS Sheffield Clinical Commissioning Group

Progressing Integrated Care System Governance

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Governing Body meeting

4 November 2021

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Purpose of Paper

This report provides an update on progress made in developing the governance arrangements in readiness for the establishment of statutory Integrated Care Systems (ICSs) on 1 April 2022.

It summarises progress, key guidance and the indicative timetable for next steps. This includes engaging on key components of the Integrated Care Board (ICB) in developing governance arrangements in readiness for the establishment of the Integrated Care System (ICS) as a statutory body from 1 April 2022.

Key Issues

- The South Yorkshire and Bassetlaw Health and Care Partnership agreed a set of arrangements to take the partnership forward. A key group of the partnership is the ICS Development Steering Group, whose membership is drawn from across all system partners and key ICS building blocks.
- The ICS Development Steering Group and the Health Executive Group have been considering the published guidance and policy including the development of partnership governance arrangements at its monthly meetings and most recently at its meeting on 14 September 2021.
- National guidance to support establishment of statutory ICS was published over August and September, including on the functions and governance of the Integrated Care Board (ICB) and Model Constitution of the ICB.
- ICS leaders and designate ICB leaders are asked to proceed with preparations to implement ICB governance and leadership arrangements.
- The chair designate is now in post and appointment to the chief executive designate is underway.
- CCGs are legally responsible for proposing the ICB Constitution to NHS England and Improvement and engaging with relevant partners. Barnsley, Doncaster, Rotherham and Sheffield CCGs have agreed a collective approach through the Joint Committee of CCGs. Key components of the Constitution, including the size and composition of the Board and the process for the ICB nomination and selection of partner members, will now be taken forward by the designate chair and designate Chief Executive Officer, once appointed. The next step to take this forward is to

engage with partners on these specific issues to get their input to shape proposals and this will follow shortly.

- Engagement with appropriate partners on key components of the Constitution are expected by 30 November 2021.

Is your report for Approval / Consideration / Noting

- **Noting**

Recommendations / Action Required by Governing Body

Governing Body is asked to:-

- Note the progress and summary of the position
- Note and consider the key activities and timetable, Annex, A
- Consider the published guidance on the functions and governance of an ICS and key elements of the Bill, Annexes B - G
- Note the legal responsibility of the CCG to propose the ICB Constitution to NHS England and Improvement.
- Note the requirement to engage with partners on the ICB Constitution
- Note the step to engage with partners on specific issues relating to the constitution later in October
- Note the priority to recruit to the first two designate non-executive directors of the ICB
- Note boundary changes and name change of the Health and Care Partnership from 1 April 22

What assurance does this report provide to the Governing Body in relation to Governing Body Assurance Framework (GBAF) objectives?

Which of the CCG's Objectives does this paper support?

This paper supports each of the five CCG objectives in addition to all identified principal risks.

Are there any Resource Implications (including Financial, Staffing etc)?

No specific resource implications associated with this report

Have you carried out an Equality Impact Assessment and is it attached?

There are no specific issues associated with this report.

Have you involved patients, carers and the public in the preparation of the report?

Not applicable

South Yorkshire and Bassetlaw
Health Executive Group

Date: 12 October 2021

Subject: Progressing ICS governance

Report of: Will Cleary-Gray, Chief Operating Officer, SYB Health and Care Partnership

Sponsor: Pearse Butler, Chair SYB Health and Care Partnership, Chair Designate South Yorkshire Integrated Care Board

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SUMMARY OF THE REPORT

This report provides an update on progress made developing the governance arrangements in readiness for the establishment of statutory Integrated Care Systems (ICSs) on April 1 ,2021.

KEY MESSAGES

SYB Health and Care Partnership agreed a set of arrangements to take the partnership forward. A key group being the ICS Development Steering Group, whose membership is drawn from across all system partners and key ICS building blocks.

Guidance to support establishment of statutory ICS was published over August and September, including on the functions and governance of the Integrated Care Board (ICB) and Model Constitution of the ICB.

ICS leaders and designate ICB leaders are asked to proceed with preparations to implement ICB governance and leadership arrangements.

The chair designate is now in post and appointment to the chief executive designate is underway.

Initial discussions on the ICB guidance and arrangements took place at the 14 September ICS Development Steering Group.

Engagement with appropriate partners on key components of the Constitution are expected by 30 November 2021

PURPOSE OF THE REPORT

This report summarises progress, key guidance and indicative timetable for next steps. This includes engaging on key components of the ICB in developing governance arrangements, in readiness for the establishment of the Integrated Care System (ICS) as a statutory body from 1 April 2022

The Health and Care Bill: Developing our governance arrangements

Purpose

1. This report summarises progress and indicative timetable for next steps in developing our governance arrangements in readiness for the establishment of the Integrated Care System (ICS) as a statutory body from 1 April 2022.

Background and context

2. South Yorkshire and Bassetlaw agreed a set of arrangements to respond to NHS England and Improvement next steps to Integrating Care, and the White Paper ***"Integration and Innovation: Working together to improve integration and innovation for all"*** This included the establishment of an ICS Development Steering group involving all partners across the ICS including Local Authorities, VCSE, Providers, including Primary Care, Mental Health and Children's Services, Commissioners and reflecting the key building blocks of our ICS including all five Places, Partnerships and Collaboratives.

3. Subsequently, the Health and Care Bill was put before Parliament on 6 July 2021 and further guidance on the governance arrangements of ICSs have been published during August and September. This includes **guidance on the functions and governance of the Integrated Care Board and model constitution for the ICB.**

4. ICS leaders, and designate ICB leaders as they are appointed, are asked to 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. CCGs are legally responsible for proposing the ICB Constitution to NHS England and Improvement and engaging with relevant partners. The four CCGs have agreed a collective approach through the JCCCG. Key components of the Constitution including the size and composition of the Board and the process for the ICB nomination and selection of partner members, will now be taken forward by the designate chair and designate CEO, once appointed. The next step to take this forward is to engage with partners on these specific issues to get their input to shape proposals - this is anticipated in the next couple of weeks and further details on this will follow.

   A summary of the timeline and key activities is attached at Annex, A

5. South Yorkshire and Bassetlaw partnership now has its Chair Designate for the Integrated Care Board and recruitment for the designate Chief Executive is underway with interviews taking place on 11 October 2021.

6. The ICS Development Steering Group and the Health Executive Group have been considering the published guidance and policy including the development of partnership governance arrangements at its monthly meetings and most recently at its meetings on 14 September 2021.

7. The transition approach with five key steps was set out and discussed at the September HEG, to enable a smooth transition to statutory ICS. Both the framework to work on functional design and undertake due diligence is underway.

Key elements of the Bill and guidance on establishing ICBs

8. A statutory ICS will be made up of a statutory NHS body – the Integrated Care Board (ICB) and a statutory joint committee - the Integrated Care Partnership (ICP) - bringing together the NHS, Local Government and partners.

A summary of the core components of ICB governance are attached in Annex B

9. The ICB will be directly accountable for NHS spend, commissioning and performance within the system. ICBs will bring partner organisations together in a new collaborative way with a 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. Statutory functions, including 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). In addition, NHSEI direct commissioning functions will be transferred or delegated starting April 2022 for Primary Medical Services with further delegation of other directly commissioned services from 2023 onwards.

A summary of the statutory functions of the ICB are attached at Annex C.

10. The core governance of the ICB will be an NHS unitary board and its membership, as a minimum, must include a chair and two further non-executives, the ICB chief executive and clinical and professional executive leaders, and partner members drawn from NHS trusts, primary care and local authorities within the ICS geography. Partner members are to be nominated and selected, as set out in the ICB Constitution, to ensure the board benefits from these important perspectives and the experiences these members will bring to enrich the leadership and decision-making of the Board. Partner members are not delegates or representatives of organisations. Other members may be determined locally.
A summary of the minimum membership of the ICB is attached at Annex D.

11. The Integrated Care Partnership is likely to be a wider group than the ICB and will develop an integrated care strategy to address the health, social care and public health needs of their system. The membership and detailed functions of the ICP will be up to local areas to decide as they form this joint committee. SYB has made significant progress co-producing its draft Health and Care Compact and a draft Terms of Reference for the refresh Health and Care Partnership, both of which have been consulted on with partners across the system and provide a good basis to build on now we have guidance from DHSC.

A summary of arrangements for ICPs are attached at Annex, E

12. A **duty to co-operate will** be introduced to promote collaboration across the healthcare, public health and social care system. ICSs, NHS England and NHS providers will be required to have regard to the '**Triple Aim**' of better health and wellbeing for everyone, better care for all people, and sustainable use of NHS resources. SYB spent some time co-producing a Compact between health and care partners which set out the share commitment to our **quadruple aim** for the people of South Yorkshire.

A summary of our commitment to the quadruple aim are attached at Annex Ei.

13. **ICBs will be able to delegate** significantly to place level and to provider collaboratives. Delegation can be internal or external and will require due diligence and delegation agreements or contracts where appropriate to give clarity and confidence of any delegation or delivery agreement.

14. **Guidance to support thriving places was published in September 2021.** Place-based arrangements between local authorities, the NHS and providers of health and care will be left to local areas to arrange. The statutory ICB will work to support places to integrate services and improve outcomes. Health and Wellbeing Boards will continue to have an important role in local places. NHS provider organisations will remain

separate statutory bodies and retain their current structures and governance but will be expected to work collaboratively with partners.

Governance options for Place-based Partnerships are attached at Annex, F.

15. **Working together as scale: guidance on provider collaboratives was published in August 2021.** Provider Collaboratives are expected to be in place by April 22 for all trust providing acute and mental health services. They are expected to agree specific objectives with one or more ICBs. ICBs and Provide collaborative must also define their working relationships for how they will contribute to the delivery of the ICB strategic objectives.

Governance options for Provider Collaboratives are attached at Annex, G.

Key governance issues

16. **Inclusivity, values and behaviours** – strong and effective governance is as much about living our values as they are about formal arrangements and structures. Critical to our success will be that our new arrangements reflect, build on and strengthen our principles and behaviours and support the culture that we have strived to established as a partnership over the last 5 years. In particular, we will ensure that the arrangements reflect that which we know, our people are what make us successful and our focus is the people we serve. We continue to make real our commitment to equality, diversity and inclusive cultures. We are keen to continue to make progress in ensuring that our leadership and involvement in decision-making reflects the diversity of our communities and are exploring how we can take this forward. Equality impact assessments will play an important role in our new arrangements.

17. **Consistency of governance standards** – our principles of subsidiarity mean that places are developing arrangements that meet their local circumstances, within a common framework of good governance. The ICS Development Steering Group considered governance standards at its meeting in 14 September 2021 which it is proposed would apply across our system. The standards cover outcomes, values, transparency, citizen involvement, diversity, independent challenge and probity and can **be seen in Annex, H.**

18. **Subsidiarity and delegation** – under statutory arrangements, the vast majority of ICS capacity and resources will remain in our place teams. Places and are developing arrangements to fit local circumstances, within the context of our core governance standards and our place development matrix, the overall operating model of the ICS and governance of the ICB. This will bring to life the concept of one organisation, one workforce working in four place teams and support delegation.

19. **Considerations in each place arrangement are:**

- Health and Wellbeing boards continuing to play a key role in bringing partners together and setting strategy.
- Building on existing strong place arrangements and relationships to enable effective collaborative decision making
- The importance of clinical and profession leadership in decision-making
- Involving statutory and non-statutory partners and ensuring that the citizen voice is heard
- Ensuring that providers working across footprints are effectively represented without duplication and overlap.

20. **Our four places** have well established arrangements involving all partners. These are being reviewed in light of the published guidance and as part of the steps to establish

statutory ICSs and the ICB. Key next steps are: i) to agree priorities and the arrangements needed to work together to deliver these priorities and ii) the relationship and arrangements needed between these and the ICB to ensure we have thriving Places within a strong and vibrant ICS.

21. **Our system provider collaboratives**: Mental Health Alliance, Acute Federation and Primary Care Collaborative and Children and Young Peoples Alliance have established arrangements. These are being reviewed in light of the published guidance and the steps to establish statutory ICSs and ICB. Key next steps are: i) to agree priorities and the arrangements needed to work together to deliver these priorities and ii) the relationship and arrangements needed between these and the ICB to ensure we have strong and vibrant collaboratives within a strong and vibrant ICS.

22. **System arrangements** – the **Integrated Care Partnership** will be a statutory joint committee between partners. The ICS Development Steering Group put forward revised arrangements for our ICP together with a Health and Care Comact of our commitment to working together, to our Trust Boards, Governing Bodies and Councils earlier this year with a view to this new arrangement being in place for the 3rd Quarter 2021. Further consideration will be given to this at the ICS Development steering group on 12th October 2021 in light of guidance on the future ICP. The Partnership Board gave oversight to the development of our five-year plan, setting out our strategic direction and how we will work together as partners to improve health and wellbeing and reduce health inequalities. The Partnership Board focuses on the wider connections between health and wider issues including socio-economic development, housing, employment and environment. It takes a collective approach to decision-making and supports mutual accountability across our system. Our current arrangements mean that we are well placed to transition to a statutory joint committee and we will be reviewing the membership and terms of reference of the Partnership Board in line with the **national guidance on Integrated Care Partnerships, now published.**

23. Our Integrated Care Partnership will set the overall strategy for our ICS, it will be built from the four place-based strategies which in turn will have been signed off by Health and Wellbeing Boards and delivered through place-based partnership arrangements. This will ensure that the specific needs of all our populations will be met at the same time as having the benefit of working as a whole system where those needs can't be met in anyone place or where to achieve equality of access, outcome, standards and quality a system approach is required.

Integrated Care Board in South Yorkshire.

24. At the ICS Development Steering Group on 14 September key components of the national guidance on governance and functions of the ICB, including its minimum membership, were presented and discussed to inform initial work on the membership and working arrangements for the ICB board in South Yorkshire. We want our board to look, feel and function in the way that make sense for our system; one which aligns with the legislation, but not completely driven by it. Our system has developed significantly over the past 5 years with Places working in partnership and collaborations and providers being a central partner. The board will be built on principles of inclusivity, independent challenge and effectiveness and will reflect the scale and complexity of a diverse system which serves a population of 1.3 million and the core functions of an ICB. It will be part of a complex, decision-making framework, focused on delivery of our shared outcomes and with independent challenge built in at all levels and strong and consistent clinical and professional leadership. The executive portfolio will be developed to ensure that the CEO accountabilities are

appropriately delegated. The proposed roles will be part of the engagement of the whole board composition, to ensure it is effective and balanced. The ICB will be a statutory core member of the ICP Joint Committee. South Yorkshire will look to discharge the ICBs statutory duties in a way that aligns much more with our approach through Places and Collaboratives and will focus its operating model and one workforce, integrating in four places and across the system to achieve this for April 2022. This reflects, recognises and respects the importance and value in giving time for the new ICB to established as a legal entity on the April 1, 2022.

25. **Committees of the ICB**. The ICB will be required to establish two statutory committees – **audit** and **remuneration**. We will also need to establish other committees to focus on oversight and assurance and provide the IC board with assurance on the delivery of key functions, including how the four key purposes of an ICS, equality of access and outcomes, quality and finance. The Partnership already has a number of effective collaborative forums such as the Health Oversight Board, the Integrated Assurance Committee, the Health Executive Group, Quality Surveillance Group, Clinical Forum and Finance Forum and People Board. Development work is focusing on how the role, membership and ways of working of these groups may need to be adapted in line with new statutory arrangements or need to end as statutory arrangements take shape.

26. **Designate non-executive members of the ICB.** ICBs are required to have, as a minimum, two non-executive members. Recruitment of the two designate non-executive members of the ICB is a priority for South Yorkshire and the final composition of the board may include more non-executives than the minimum and this will be part of the engagement of the full composition of the ICB. It is anticipated that the national process to enable local recruitment to progress will be up and running week commencing 11 October 2021. South Yorkshire plans to progress its non-executive recruitment as soon as possible after that date.

Boundary changes and ICB naming convention

27. As part of the changes, we are proposing a name change for our ICS from April 2022 to South Yorkshire Health and Care Partnership. In addition, the naming convention approach for ICBs is anticipated. It's important to note that whilst Bassetlaw place will be part of the Nottingham and Nottinghamshire Health and Care Partnership (ICS), our work with Bassetlaw will continue both in terms of the strategic partnership with the Nottinghamshire and Nottingham ICS, Doncaster and Bassetlaw NHS Teaching Hospital Foundation Trust (and the work of the Acute Federation of Hospitals) and wider clinical and professional networks. Existing patient flows will be unaffected by this change to the boundary and this joint working is critical for the population of Bassetlaw.

Simplifying arrangements

28. Our **ICS Development Steering Group** has served as the working group for our work on Governance to date and this is chaired by our ICS lead. It has representation from across our places, providers and sectors including NHS commissioners, provider collaboratives, local authorities, voluntary, community social enterprise (VCSE). This group has enabled sharing across each of our places and system, advising on where consistency is helpful and on the linkages between place, ICB and ICP arrangement. It has also steered the co-production of key products including, the Health and Care Compact, revised terms of reference for the Health and Care Partnership and a development matrix for place-partnership development We want to simplify our arrangements as we move into the final six months to implementation of statutory

ICSs, to make it even easier for all key partners to engage in this important work. Two changes are proposed at this stage: i) Regular briefing to inform discussions into the weekly **Health and Care Management meetings**. ii) Amending the terms of reference of the **Health Executive Group** to reflect a renewed focus on ICS development and invite any regular remaining members from the Steering Group to join this group which has to date, taken place on the same day. It is proposed that this change takes place from November and therefore October will be the last meeting of ICS steering group as a separate meeting.

Recommendations:

The Health Executive Group is asked to:

- Note the progress and summary of the position
- Note and consider the key activities and timetable, Annex, A
- Consider the published guidance on the functions and governance of an ICS and key elements of the Bill, Annexes B- G
- Note the requirement to engage with partners on the ICB Constitution
- Note the step to engage with partners on specific issues relating to the constitution later in October
- Note the priority to recruit to the first two designate non-executive directors of the ICB
- Note boundary changes and name change of the Health and Care Partnership from 1 April 22
- Agree changes to simplify arrangements from November 2021

ANNEXES

Annex, A

Table 1: Areas, activities and timescales

Area	Activity	Timescales
Constitution	• 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 ICBs[4] 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.	• Development of the constitution to take place throughout the year. • Board size and composition **by 17/11/21** • All other aspects including the nomination and selection process for partner members **by 30/11/21** • A final version approved **before the end of Q4** by NHS England and NHS Improvement.
Board recruitment	• Plan how the board of the ICB will be populated.	• 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	• Confirm plans to ensure that commissioning functions are organised across the ICS footprint including apportioning between the ICB (system) level and 'place' level.	• Discussions with partners and decisions on commissioning arrangements at system and place to be finalised **by the end of Q3.**
Functions and decision map	• Develop a 'functions and decision map' showing the arrangements with ICS partners to support good governance and dialogue with internal and external stakeholders.	• 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.

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

Annex, B

Table 2: Core components of ICB governance arrangements and expectations

Core component	Expectation
Integrated care partnership (ICP) ***statutory***	• 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 ***statutory***	• 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	• 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 (may be at sub system, system or supra-system level)	• 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.

Annex, C

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	Arranging for the provision of health services in line with the allocated resources across the ICS through a range of activities including: 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 lead[6] 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.

	including through investment in PCN management support, data and digital capabilities, workforce development and estates 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.
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

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.

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

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

Annex, D

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
Independent non-executive members	Chair	• 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	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
Executive roles	Chief Executive	• Must be employed by / seconded to the ICB
	Chief Finance Officer	• Must be employed by / seconded to the ICB
	Director of Nursing	• Must be employed by/seconded to the ICB
	Medical Director	• Must be employed by/seconded to the ICB
Partner members (a minimum of three)	At least one member drawn from NHS trusts and foundation trusts that provide services within the ICS's area	• 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	• 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.	• We expect this partner member will often be the chief executive of their organisation or in a relevant executive- level local authority role
*All members of the ICB *ICBs will be able to supplement the minimum board positions*	As listed above and additional members.	Each member of the ICB must: • 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.

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

Annex, E

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

Extract from the Integrated Care Partnership: engagement document, September 21

Representatives and organisations for ICP membership and engagement

We expect the ICP to have a broad membership and engagement with the organisations and communities it serves. However, this membership should be managed appropriately to ensure that the operations of the ICP remain efficient and effective. This illustrative list for ICP membership and engagement should not be viewed as a box-ticking exercise but as a genuine way of ensuring the partnerships include people able to represent and connect with communities and the voluntary sector. We welcome perspectives on whether there are any other voices who should form part of this list. For example:

- voices for children & young people
- patients, service users, & public voices
- voluntary, charity and social enterprise sector
- voices from the Children's Board
- led by and for women's organisations
- Black and minoritised voices
- Healthwatch
- social care providers and workforce
- unpaid carers voices
- disability voices
- mental health providers and service users
- primary care (GPs, dental, eye care, pharmacy)
- NHS Trusts and Foundation Trusts (acute, mental health, community, ambulance)
- community care
- public health voices (e.g., Directors of Public Health)
- local Authority Officers (e.g., Director of Children's Services, Director of Adult Services)
- Acute Care
- housing voices
- Criminal Justice System agencies, including probation services
- offenders health and care voices
- alcohol and addiction services
- homeless services
- social prescribing services
- learning disabilities and autism providers and service users
- businesses
- Local Enterprise Partnerships
- armed forces
- police and crime commissioners
- employment support services (e.g., Jobcentre Plus)

Extract from the draft Health and Care Compact co-produced with all partner members of the ICS development steering group

Annex, Ei

Values and Principles for the ICS Partnership

The partners recognise that achieving the Shared Purpose will depend on their ability to effectively co-ordinate themselves in order to deliver an integrated approach to the provision of services across the ICS. This may include (if partners choose) combining expertise, workforce and resources and also a review of how the Health and Wellbeing Boards in each of the five Places can play a key role in the development and structure of the Partnership.

The partners also wish to support each other in the development of successful place based systems within the ICS for Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield, which will each work as an effective part of the wider system and key building block. Members will also deploy appropriate resource to support the Partnership (each member retains ownership of its resources and is solely responsible for decisions about how those resources are used).

The members will embrace the following values:

- The **'quadruple aim'** of 'better health and wellbeing for the whole population, better quality care for all patients and sustainable services for the people alongside the reduction of health inequalities
- Recognising the critical importance of the workforce, to work closely together to develop and support the wider workforce of the members operating across the system
- To play their part in social and economic development and environmental sustainability of the SYB region
- Committing to making decisions
- Always keeping citizens at the centre of everything the partners do
- Ensuring that the children's, young people and families agenda is a key element of this work
- Supporting each other and working collaboratively to take decisions at the most local level as close as possible to the communities that they affect whether that be system, place or neighbourhood (subsidiarity) and not to simply replicate what is at place in the ICS
- Developing collaborative leadership to deliver the Shared Purpose, and a culture and values to support transformation. All partners are respected and valued. They understand their own contribution and support the contributions of other partners to the Shared Purpose
- Strengthen the links between Place and ICS as well as other local representative structures such as Health and Wellbeing Boards and demonstrate inclusivity and shared ownership
- Making time and other resources available to develop the Partnership and deepen working relationships between partners at all levels
- Being transparent with each other and the people of SYB around decisions and appointments
- Using the best available data to inform priorities and decision-making
- Looking for simplicity and effectiveness in any Partnership structures and governance and follow the rule of form following function

- Acting with honesty and integrity and trusting that each other will do the same; This includes each member being open about the interesss of their organisation and *any* disagreement *they* have with a proposal or analysis. Partners will assume that each acts with good intentions: and
- Working to understand the perspective and impacts of their decisions on other parts of the health and social care system
- Decisions should be taken together at the right level to deliver the Shared Purpose and benefit the population of SYS. Decisions around resource at place should be made with the relevant partners at the place level and when decisions are taken together across the SYS system *they* should not adversely affect the outcomes or equity for populations within SYBICS

...together these are the 'Values'.

The ways in which the members will put the Values into practice include:

- Promoting and striving to adhere to the Nolan Principles of public life (selflessness. integrity. objectivity, accountability. openness, honesty and leadeship) including:
- Specifically being accountable to each other for performance of respective roles and responsibilities for the Partnership and the ICS, in particular where there is an interface with other members; and
- Communicating openly about major concerns. issues or opportunities relating to this Compact and adopting transparency as a core value, including through open book reporting and accounting. subject always to appropriate treatment of commercially sensitive information if applicable
- Having conversations about supporting the wider health and care system. not just furthering their own organisations' interests
- Undertaking more aligned decision-making across the partners and trying to commission and deliver services in an integrated way wherever reasonably possible
- Routinely using insights from data to inform dec ion making
- Positive engagement with other partners in other geographies in pursuit of the quadruple aim and effective planning and delivery including Clinical and Professional Networks
- Ensure that problems are resolved where possible rather than being moved around the system
- Acting promptly. Recognising the importance of integrated working and the Partnership and responding to requests for support from other partners
- Seeking to ensure that our organisations reflect the diversity of the population and that this is reflected in the governance and dec ion making groups for the system

...together these are the 'Principles'.

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

Annex, F

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 partnerships[11]

Consultative forum Helpful for engaging the widest range of partners to discuss and agree shared strategic direction together.	A collaborative forum to inform and align decisions by relevant statutory bodies, such as the ICB or local authorities, in an advisory role. In this arrangement, the decisions of statutory bodies should be informed by the consultative forum.
Individual executives or staff Helpful for engaging partners in the decision-making of statutory bodies, while retaining a single SRO for decisions.	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. 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.

[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.

Committee of the ICB Helpful for making decisions of the ICB based on a range of views	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. 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.
Joint committee Helpful for making joint decisions between relevant partners	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. 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.
Lead provider Helpful for giving provider leaders greater ownership and direction around the delivery and coordination of services.	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. 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.

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.

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

Annex, G

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 (e.g. 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

Annex, H

DRAFT ICS Governance standards

(Applicable to the ICP and ICB, joint committees, committees and sub committees with delegated authority from the ICB.)