Working Paper
Analysis of the Health and Care Bill 2021-22
Governance of Integrated Care Boards and Integrated Care Partnerships

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1. Introduction

This summary outlines the proposals of the Health and Care Bill regarding the governance of ICSs. The Bill went before Parliament in July 2021, following the publication of the White Paper '*Integration and Innovation: working together to improve health and social care for all'* (February 2021) which set out legislative proposals for the Bill.

This summary will firstly recap the proposals of the White Paper as the relate to the governance of ICSs, secondly outline the relevant sections of the Bill, and thirdly consider the implications of the Bill.

2. The White Paper – Proposals relating to the governance of ICSs

The White Paper put forward a number of proposals to: remove the barriers to health and care system integration; use legislation to remove transactional bureaucracy that has made decision-making harder; and ensure a system that is more accountable and responsive.

Part of these proposals related to the creation of statutory Integrated Care Systems (ICSs).

The White Paper proposed that every part of England was to be covered by a statutory ICS, consisting of an ICS Health and Care Partnership which brought together the NHS, local government and partners, and an ICS NHS Body. The ICS NHS body would be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership brought together systems to support integration and develop a plan to address the systems' health, public health, and social care needs.

The White Paper suggested that the legislation would be designed to provide a small set of consistent requirements for each system that the partners who make up that system can then supplement with further arrangements and agreements that suit them.

Ahead of the Bill, NHS England issued guidance (*ICS Design Framework (NHS England and NHS Improvement, 2021a))* which anticipated the content of the Bill and aimed to provide guidance relating to the function and governance of statutory ICSs which would help current bodies prepare for statutory ICSs to commence in April 2021. This has been complemented by additional interim guidance to help systems prepare for the establishment of the statutory ICBs and ICPs, subject to the passage pf the Health and Care Bill through Parliament. This guidance sets out the proposed core components of governance arrangements of the ICB (*Interim guidance on the functions and governance of the Integrated Care Board (NHS England and Improvement, 2021)*), and in ICPs (*Integrated Care Partnerships engagement document (DHSC and NHS England and Improvement, 2021))*, the

development of arrangements in places (*Guidance on the development of place-based partnerships as part of statutory integrated care systems (NHS England and NHS Improvement and Local Government Association, 2021)*), and provider collaboratives (*Working together at scale: guidance on provider collaboratives (NHS England and NHS Improvement, 2021b)).* This guidance is referenced throughout this analysis where appropriate.

The ICS Body

The White Paper proposed that the ICS NHS body would be responsible for the day to day running of the ICS, and NHS planning and allocation decisions. Under the White Paper proposals ICSs would be accountable for outcomes of the health of the population. The ICS NHS Body would merge functions currently being fulfilled by non-statutory STPs/ICSs with the functions of a CCG, bringing together the allocative functions of CCGs with the current strategic planning function of ICSs. Proposed responsibilities consisted of:

- Developing a plan to meet the health needs of the population within their defined geography;
- Developing a capital plan for the NHS providers within their health geography;
- Securing the provision of health services to meet the needs of the system population.

The White Paper envisaged some flexibility regarding ICS functions. It was proposed that NHS England would have the freedom to delegate or transfer the commissioning of certain specialised services to ICSs singly or jointly, or for NHS England to jointly commission these services with ICSs.

In relation to governance, it was proposed that ICS NHS body would have a unitary board, directly accountable for NHS spend and performance within the system. The board would, as a minimum, include a chair, the CEO, and representatives from NHS trusts, general practice, and local authorities, and others determined locally, and non-executives. This ICS NHS Body would be given a duty to meet the system financial objectives which require financial balance to be delivered. Although the ICS NHS Body would not have the power to direct providers, it was proposed that a new duty to compel providers to have regard to the system financial objectives would be introduced, so both providers and ICS NHS Bodies were mutually invested in achieving financial control at system level.

It was the intention of the White Paper that proposals would allow for the ICS NHS Body to delegate significantly to place level and to provider collaboratives.

ICS Health and Care Partnership

The White Paper proposed that each ICS would also be required to establish an ICS Health and Care Partnership. Members of the ICS Health and Care Partnership could be drawn from a number of sources including HWBs, partner organisations with an interest in health and care (including Healthwatch, voluntary and independent sector partners and social care providers), and organisations with a wider interest in local priorities (such as housing providers).

This Partnership would be tasked with promoting partnership arrangements with responsibility for developing a plan that addresses the wider health, public health, and social care needs of the system.

The ICS NHS Body and Local Authorities would have to have regard to that plan when making decisions., and developing a plan to address the health, social care and public health needs of their system. Each ICS NHS Body and local authority would have to have regard to this plan. The Health and Care Partnership would not impose arrangements that are binding on either party, given this would cut across existing local authority and NHS accountabilities.

Other means of securing collaboration
The White Paper proposals additionally sought to remove barriers to integration through freedoms regarding joint committees, collaborative commissioning approaches and joint appointments. The Paper proposed to create provisions relating to the formation and governance of joint committees and the decisions that could be appropriately delegated to them; and by allowing NHS providers to form their own joint committees. It was proposed that both types of joint committees could include representation from other bodies such as primary care networks, GP practices, community health providers, local authorities or the voluntary sector.

These provisions would allow ICSs to enter into collaborative arrangements for the exercise of functions that are delegated to them, enabling a "double-delegation". Groups of ICSs would be able to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions (and not just commissioning functions). A greater range of delegation options would be enabled for section 7A public health services, including the ability for onward delegation of the function into collaborative arrangements, such as a section 75 partnership arrangement

In order to facilitate collaboration across bodies in the health and social care system, the White Paper contained new proposals for a new duty to collaborate on NHS organisations (both ICSs and providers) and local authorities (replacing the two existing duties to cooperate in legislation), supported by the "triple aim duty". The Triple Aim was described as requiring health bodies, including ICSs, to ensure they pursue simultaneously the three aims of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources.

3. The proposals of The Health and Care Bill

The Bill proposes the establishment of statutory bodies, Integrated Care Boards (ICBs), and statutory committees, Integrated Care Partnerships (ICPs).

i. Integrated Care Boards

Under the proposals of the Bill, ICBs will be established by NHS England. As is currently the case with ICSs and CCGs, ICBs must not coincide or overlap with the area of any other ICB (*Clause 13*). While the Explanatory Notes to the Bill suggest that the populations covered by ICBs will continue to be defined in relation to GP registration, the Bill states that further clarification determining the people for whom ICBs have responsibility will be published by NHS England (*Clause 14)*.

The Bill lays out the process for establishing the constitution of the ICB. Much of the detail is contained in Schedule 2 of the Bill.

The responsibility for proposing the constitution of the ICB falls to the outgoing CCG(s) in the area. There is a requirement for these CCG(s) to consult 'any persons they consider it appropriate to consult' *(14Z26, 3).* NHS England has the right to determine the constitution itself if it considers the proposal 'inappropriate' or that the consultation carried out has not been 'appropriate' *(14Z26, 4).* Where CCG (s) do not put forward a proposal in a 'reasonable period', NHS England can also establish an ICB itself *(14Z26, 5).* The constitution must be published.

Under paragraph (14), the constitution must detail the process for how the constitution can be amended. The Bill stipulates that the constitution can be varied by the board, but also must include provision for NHS England to vary the constitution (14 (2)), and for NHS England's approval to be obtained before the constitution is varied. The Explanatory Notes state that NHS England will issue a model constitution to assist ICBs in developing their own.

Table 1:Items required in the constitution

How members will be appointed
Terms of membership (duration, replacement etc)
Statement of principles regarding register of interests
Procedure to be followed in making decisions
The arrangements to be made for securing transparency about the decisions of the board and the manner in which they are made
Statement about the principles for public involvement and how they will be implemented
Process by which the constitution can be amended
How the integrated care board is choosing to exercise its functions (e.g. delegation to committees)

Membership of ICB

Schedule 2 of the Bill contains some minimal stipulations for the membership of the board, namely that:

- the board must consist of a) a chair b) a chief executive c) at least three other members.
- the chair must be appointed by NHS England, with the approval of the Secretary of State (4), and can only be removed by them (5).
- the chief executive must be appointed by the chair, with the approval of NHS England 6 (1).

The process for the appointment of the other board members is a matter for local agreement, with the approval of the chair. Other members should include:

> (a) one member nominated jointly by the NHS trusts and NHS foundation trusts that— (i) provide health services within the ICB's area, and (ii) are of a prescribed description;
> (b) one member nominated jointly by persons who— (i) provide primary medical services within the integrated care board's area, and (ii) are of a prescribed description, and
> (c) one member nominated jointly by the local authorities whose areas coincide with, or include the whole or any part of, the integrated care board's area.

It is noted that there may also be further guidance on the selection of these members from NHS England (4) which boards should adhere to.

Beyond these stipulations, membership is largely a matter for local specification in the local constitution. Aspects to be covered in the constitution should include: how members are to be appointed; qualification and disqualification of members; the tenure of members; eligibility for reappointment; terms of appointment; and proceedings in the event of a vacancy (8).

Further expectations around ICB membership in addition to the minimum requirements of the Bill has been issued in guidance (NHS England and NHS Improvement, 2021a, NHS England and Improvement, 2021). It is expected that the ICB should consist of a minimum of two other independent non-executive members, Chief Executive, Chief Finance Officer, Director of Nursing and a Medical Director, all of which are appointments to be approved by the ICB Chair. Guidance has also clarified expectations regarding the conduct of ICB members who will be required to comply with the criteria of the fit and proper person test and uphold the Seven Principles of Public Life (the Nolan Principles). The ICB will have a unitary board, which means all directors are collectively and corporately accountable for ICB performance. In terms of the responsibilities of members, it is suggested that the three 'partner' members (representatives from Trusts, primary medical services and local authorities) will bring knowledge and a perspective from their sectors, but not act as delegates of those sectors. It is also indicated that details regarding the organisations that can take part in any nomination process will be set out in regulations later this year.

Conflicts of interest

ICBs are required by the proposals of the Bill to maintain one or more register of interests for a) members of the board b) members of its committees or sub-committees and c) employees, which must be published or publicly available on request (*Clause 13* -14Z30). Persons in the register must '*declare any conflict or potential conflict of interest that the person has in relation to a decision to be made in the exercise of the commissioning functions of the integrated care board'*, and must do so within 28 days of becoming aware of the conflict or potential conflict (*Clause 13* 14Z30 3). ICBs are required to make arrangements to manage 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 (*Clause 13* 14Z30 4).

The constitution must include a statement about the principles to be followed by the board regarding the register of interests (*Schedule 2 12*), the procedure to be followed by the ICB in making decisions 11 (1), and the arrangements to be made for securing transparency about the decisions of the board and the manner in which they are made (11 (2)).

Guidance indicates that in addition to abiding by the process specified in the Bill, members of the board or committees will need to abide by their own organisation's Conflicts of Interest policies (NHS England and Improvement, 2021). The guidance also lays out the broad principles that ICBs will be expected to follow when establishing local arrangements for managing conflicts. These are that firstly, decision-making must be geared towards meeting the statutory duties of ICBs at all times, including the triple aim, secondly it should not be assumed that statutory NHS providers, local authority and primary medical services (general practice) are personally or professionally conflicted just by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations,

and thirdly that 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 (ibid.).

Public involvement

The constitution must also include a statement about the principles for public involvement and how they will be implemented (*Clause 13*). The ICB must ensure individuals to whom care is being provided must be involved in planning/commissioning arrangements, the development of proposals for changes to commissioning arrangements affecting services (14Z44(2).

Decision making

The Bill does not address the process by which ICBs will reach their decisions. Guidance regarding ICB governance suggests that systems should use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate (NHS England and NHS Improvement, 2021a). It is also indicated that the ICBs constitution may provide for a vote to be taken where consensus cannot be reached and set out how the vote will be conducted (for example, the chair having the casting vote). However, voting should be considered a last resort rather than a routine mechanism for board decision-making (ibid.).

ii. Integrated Care Boards: Functions

ICBs are given various duties in the Bill (*Clause 19 General functions* **–** *14Z32-14Z43*). These duties are:

- to promote the NHS Constitution
- to exercise its functions effectively efficiently and economically
- to exercise its functions to secure continuous improvement in the quality of services and outcomes
- to exercise its functions to reduce inequalities of access and outcomes
- to exercise its functions to promote the involvement of patients and carers in decisions relating to prevention/diagnosis and treatment/care
- to enable patients to make choices with respect to aspects of health services provided to them
- to take appropriate advice regarding public health and prevention/diagnosis /treatment
- to promote innovation
- to promote research on matters relevant to the health service, and the use of evidence obtained from research
- to promote education and training
- to promote integration where this would improve the quality of services (including outcomes), reduce inequalities of access, reduce inequalities of outcomes, improve integration of health services with health-related (inc housing) or social care services where this would improve the quality of health services (including outcomes), reduce inequalities of access and outcome
- to have regard to the **wider effect of decisions** in relation to the health and well being of people, the quality of services, efficiency and sustainability in relation to the use of resources*

*this is referred to as the ‘triple aim’ which is being introduced for ICBs, NHS Trusts and Foundation Trusts (see below)

New section 14Z49 stipulates that NHS England must publish guidance for ICBs on the discharge of their functions. The *ICS Design Framework* summarises the functions of ICBs and gives specific guidance regarding the aims ICBs should have when discharging their functions. For example, in relation to arranging the provision of services, the guidance specifies the expectation that ICBs should put in place strategic, long-term and outcome-based contracts and agreements in place to secure delivery of its plan by providers, with providers responsible for designing services and interventions to meet agreed system objectives.

Commissioning

ICBs will take on the commissioning functions of CCGs.

Clause 15 amends section 3 of the NHS Act to require ICBs to commission hospital and other health services for the people for whom the ICB is responsible. Services listed are hospital accommodation, other accommodation, dental services (other than primary dental services), nursing and ambulance services, services for pregnant women, breastfeeding women and young children, services to prevent illness, and care for people who have suffered from illness, and other services required for the diagnosis and treatment of illness.

Clause 16 inserts Schedule 3 which amends the NHS Act 2006 to give ICBs functions in relation to medical, dental and ophthalmic primary care functions. ICBs may also be given responsibility for functions relating to pharmaceutical services. Currently, the functions associated with arranging these services sit with NHS England.

The Explanatory Notes state that:

> *(286) Schedule 3 confers functions on integrated care boards in relation to primary care services and contains related amendments. It makes amendments to the NHS Act 2006 and consequential amendments to related legislation for the conferral of medical, dental and ophthalmic primary care functions on Integrated Care Boards (ICBs). Currently, the functions associated with arranging these services sit with NHS England.* ***The intention is that Integrated Care Boards will hold the majority of these functions at an agreed point in the future.*** *NHS England will retain a limited role in oversight and discharging functions that can be most effectively exercised at a national level.*

Further guidance from NHS England (NHS England, July 2021) has confirmed that from April 2022 ICBs will assume delegated responsibility for primary medical services, be able to take delegated responsibility for dental, general ophthalmic services and pharmaceutical services, and establish mechanisms to strengthen joint working between NHSE and the ICS where those services are not already delegated. This guidance also refers to additional expectations for April 2023, including that all ICBS will by then have responsibility for dental, general ophthalmic services and pharmaceutical service, and responsibility for further ‘specialised’ services, potentially for some public health services, and some health and justice, sexual assault and abuse services.

Public Health

Clause 34: Arrangements for exercise of public health functions allows for any of Secretary of State's public health functions to be exercised by NHS England, an ICB, a local authority that has duties to improve public health, a combined authority, or any other body that is specified in regulations. Powers may be exercised in relation to payments as well as the prohibition or restriction of further onward delegation of the function or its joint exercise by a joint committee. Once a party has been delegated a public health function it is liable for the exercise of that function.

Clause 35 allows the Secretary of State to direct one or more relevant bodies (NHS England and ICBs) to exercise any of the public health functions of the Secretary of State. These are duty to take steps to protect public health, power to take steps to improve public health or certain functions under Schedule 1.

Delegation of functions to ICBs

The functions of an ICB are not fully specified by the Bill: some functions are subject to further decision making by NHS England or the Secretary of State including the dental and ophthalmic primary care functions and public health functions referred to in the preceding paragraphs.

The Memorandum from the Department of Health and Social Care to the Delegated Powers and Regulatory Reform Committee (Department of Health and Social Care, 2021) explains this issue as:

> *In addition, in relation to certain commissioning functions and public health functions, NHS England may determine that ICBs are better placed to determine the needs of their populations and can therefore be given responsibilities in these areas where appropriate. The reasons this cannot be set out on the face of the Bill is that it will very much depend on the types of service, and the growing maturity of ICBs as to which services should be delegated from a national to a local level, and when. (57 – 58)*

Those function referred to by *Clause 7: Exercise of functions relating to provision of services* may be delegated to ICBs by NHS England. The Explanatory Notes highlight that '*even where there is no agreement between NHS England and integrated care boards to enter into section 65Z5 [joint working and delegation] arrangements, NHS England can nevertheless delegate relevant functions to integrated care boards'* (237).

'Relevant' functions are described as falling into three categories:

a. Commissioning functions under section 3B(1) (dental services, services or facilities for members of the armed forces or their families, services or facilities for persons who are detained in a prison or in other accommodation of a prescribed description, such other services or facilities as may be prescribed),
b. any function of NHS England, not within paragraph (a), that relates to the provision of—(i) primary medical services, (ii) primary dental services, (iii) primary ophthalmic services, or (iv) services that may be provided as pharmaceutical services, or as local pharmaceutical services
c. Public health functions

Additionally, ICBs can be prohibited or restricted by NHS England from further delegating these delegated functions (13YB(4)).

The Secretary of State can intervene when NHS England wishes to delegate one of these relevant functions to an ICB by imposing limitations or conditions on the functions that NHS England may delegate to ICBs (Section 13YB(3)). *The Memorandum from the Department of Health and Social Care to the Delegated Powers and Regulatory Reform Committee* (Department of Health and Social Care, 2021) suggests this power is retained in the light of the Secretary of State's overall responsibility for the health service, where it becomes apparent to the Secretary of State that the appropriate body to carry out these functions is NHS England not ICBs. Alternatively, instead of preventing the delegation, restrictions or limitations can be placed upon it using this power.

Other functions
The Bill details a number of other functions which enable the ICB to act like a usual NHS authority with employees and a financial brokering role. For example, the ICB may appoint employees, and determine their remuneration and allowances, and terms and conditions (17 1). It may also pay allowances to members of committees and sub-committees (19).

iii. Integrated Care Partnerships

Integrated Care Partnerships (ICPs) are joint committees which are required to be established by an ICB and each responsible local authority whose area coincides with or falls wholly or partly within the board's area (*Clause 20 (4)).* The Bill stipulates the ICP should consist of:

(a) one member appointed by the integrated care board,
(b) one member appointed by each of the responsible local authorities, and
(c) any members appointed by the integrated care partnership (Clause 20 (4))

Under the Bill it is for each local ICP to decide how to conduct the remainder of its business (its own 'procedure' (including quorum)) (subsection 3).

Guidance puts forward a number of expectations regarding the governance of ICPs, which expand on the requirements of the Bill. The *Explanatory Notes* suggest the ICP should bring together health, social care, public health (and potentially representatives from the wider public space where appropriate, such as social care providers or housing providers), although not necessarily as members Public health experts will be expected to play a significant role in ICPs, specifically LA directors of public health, and additionally ICPs will be expected to draw on input from representatives of adult and children's social services, relevant representation from other local experts, including HWB chairs, primary or community care representatives and other professional leads, appropriate representation from providers of health, care and related services, the VCSE sector and a representative from Healthwatch (NHS England and NHS Improvement, 2021a, DHSC and NHS England and Improvement, 2021).

Guidance specifies further expectations regarding ICP governance. It is advised that ICPs should consider their fit with other governance arrangements such as HWBs in order to maximise alignment between partners and the community and ensure effective joined up decision making, for example through common membership . In order to streamline governance across the ICS it is suggested that some systems may choose that the ICP and ICB share chairs to help ensure co-ordination . It is also suggested that ICPs will need to be transparent with formal sessions held in public and its work communicated to stakeholders in clear and inclusive language (DHSC and NHS England and Improvement, 2021, NHS England and NHS Improvement, 2021a).

iv. Joint working and the delegation of functions

The Bill outlines various options through which an ICB may choose to exercise its functions, and the locally chosen options must be identified in the constitution. These are the appointment of committees or sub-committees of the integrated care board; and the inclusion in these of people who are not employees of the board or a member of the board (Schedule 2 10 2). The *Explanatory Notes* give the example of exercising budgets and functions to 'place'-level committees of the integrated care board as is locally appropriate. All ICB functions can be exercised on behalf of the ICB by (a) any of its members or employees, or (b) a committee or sub-committee of the board (10 3).

The *Explanatory Notes* explain the significance of this difference:

> *[The ICB] will have the ability to exercise its functions through place-based committees (while remaining accountable for them) and it will also be directly accountable for NHS spend and performance within the system. (38)*

A further important aspect of working in ICBs relates to the joint exercise of functions. Clause 60: *Joint working and delegation arrangements* introduces new flexibilities by which NHS England, an ICB, an NHS Trust, an NHS FT or any other 'prescribed' body may arrange for any functions exercisable by it to be exercised by or jointly with any one or more a relevant body (NHS England, an ICB, an NHS Trust, an NHS FT or any other 'prescribed' body); a local authority; or a combined authority. This includes functions that have already been delegated to a relevant body. However, it is also that case that Regulations may provide that this power does not apply, or applies to a prescribed extent, or is subject to other conditions (Section 65Z5(3)). Powers under this section may also prohibit or restrict the further onward delegation of a function that has already been delegated. The document *The Memorandum from the Department of Health and Social Care to the Delegated Powers and Regulatory Reform Committee* (Department of Health and Social Care, 2021) explains this issue as:

> *The delegated power provides flexibility to specify what functions may not be exercised jointly with or by another body or what functions can be exercised on behalf of, or jointly with another body. Delegating the power avoids the need to set out in primary legislation detailed provisions about the services to be provided and the groups to whom they must be provided. The arrangements under these clauses enable new and different approaches to the exercise of functions, which would need to be reviewed and developed in a flexible manner as they could change over time. There are a wide range of delegable functions, carrying very different risks which might require different conditions. The Secretary of State having the power to make*

regulations allows for this flexibility and avoids the delay that would be caused by needing to pass primary legislation..(400-401)

Where a body has agreed to jointly exercise a function with another body, the parties jointly exercising the function may set up a joint committee in order to exercise the function (65Z6), and may also establish and maintain a pooled fund in order to exercise the function[1]. The parties jointly exercising the function may agree between themselves the terms of their respective liabilities in relation to the joint exercise of the function.

The Explanatory Notes suggest that these joint committees could include representation from other bodies such as primary care networks (PCNs), GP practices, community health providers, local authorities or the voluntary sector (50).

It is intended that NHS England will issue guidance under section 65Z7 about how joint committee arrangements could be administered and how liability arrangements could be decided. Regulations made under section 65Z5(3) may also impose conditions on what functions can be placed in a joint committee and how it should operate. The document *The Memorandum from the Department of Health and Social Care to the Delegated Powers and Regulatory Reform Committee* (Department of Health and Social Care, 2021) justifies this as follows:

> *'It would not be desirable to write the content of the guidance on information processing into primary legislation. It is likely to include administrative and technical details, and to need updating more frequently than writing it into primary legislation would allow. Justification for the procedure. The requirements in the guidance are likely to be detailed and to be subject to change from time to time depending on the delegation and joint committee arrangements. Given the procedural content of the guidance, a Parliamentary procedure is considered unnecessary' (405-406)*

v. Collaborative working

Joint Appointments

The Bill proposes to create a power for NHS England to publish guidance on the use of joint appointments by NHS commissioners and NHS providers (Clause 63).

The *Memorandum from the Department of Health and Social Care to the Delegated Powers and Regulatory Reform Committee* (Department of Health and Social Care, 2021) explains that this is in response to a previous lack of clarity about the ability to pursue joint appointments across organisational types:

> *By issuing guidance, NHS England will be able to reduce uncertainty over when joint appointments are appropriate. It is intended that this will reduce both the likelihood that an*

[1] The Explanatory Notes describe a pooled fund as a *'fund to which the parties jointly exercising the function have contributed and out of which payments can be made in the exercise of functions under the arrangements'*.

> *organisation would be inhibited from making a joint appointment if appropriate, or that an organisation would make an inappropriate joint appointment. Organisations will be prompted to consider whether conflicts of interest will arise and whether effective arrangements to manage any conflicts will help mitigate the risk that inappropriate joint appointments are pursued (419).*

Joint appointments are specified as appointments of a person to a position in both a commissioning body and an NHS provider, and/or a position in both an NHS body and a local authority or combined authority.

Duty to Cooperate

The Bill introduces a new power that allows the Secretary of State to issue guidance on cooperation between NHS bodies, and between NHS bodies and local authorities. NHS bodies already have a duty to co-operate with each other under Section 72 of the NHS Act 2006. Clause 64 (2) of the Bill inserts a new power into section 72 of the NHS Act 2006 for the Secretary of State to make guidance on how this duty is discharged

The Explanatory Notes suggest that new guidance will give organisations greater clarity about what the duties to cooperate mean in practice, helping DHSC to build on the innovation, working relationships and positive behaviours that have been seen over the past year.

Removal of Duty to Promote Autonomy

Clause 62 of the Bill amends the NHS Act 2006 by removing the Secretary of State and NHS England's duties to promote autonomy. Currently Clause 1D and 13F of the 2006 Act states that the Secretary of State and the Board (NHS England) respectively, in exercising their functions, '*must have regard to the desirability of securing, so far as consistent with the interests of the health service (a)that any other person exercising functions in relation to the health service or providing services for its purposes is free to exercise those functions or provide those services in the manner it considers most appropriate, and (b)that unnecessary burdens are not imposed on any such person.*

The Explanatory Notes (572) state that the rationale for removing these duties is *'to ensure that they do not conflict with duties for system partners to cooperate and think more broadly about the interests of the wider health system.'*

Triple Aim

The Bill introduces what was known in *The White Paper* as the 'Triple Aim', a duty on NHS organisations to consider the effects of their decisions on the better health and wellbeing of everyone, the quality of care for all patients, and the sustainable use of NHS resources. This duty (in the Bill referred to as the 'Duty to have regard to wider effect of decisions') is to be imposed on bodies that arrange NHS services (NHS England (Clause 4) and ICBs (Clause 19 (2)) and NHS providers of care (Trusts (Clause 43) and Foundation Trusts (Clause 57).

The Explanatory Notes state that *'This new duty will require organisations to think about the interests of the wider system and will provide common, system-wide goals that need to be achieved through collaboration'*

Licence conditions

The Bill also proposes changes regarding the provider licence (required for NHS FTs and independent providers of NHS services) to ensure that the licence does not interfere with the 'triple aim' and duty to co-operate.

The Bill proposes to give Monitor (in future, NHS England) power to modify standard licence conditions in all providers' licences. Section (4)(a) amends section 96(2)(g) and section 96(3) of the 2012 Act which allowed Monitor to modify license conditions (such as those regarding competition) if the purpose was to enable co-operation to achieve the improvement of the quality of health care services or the efficiency of their provision; reduced inequalities in people's ability to access those services; or reduced inequalities of outcomes. The proposed changes will allow NHS England to modify licence conditions to enable co-operation without this being conditional on satisfying the above objectives (see Explanatory Notes 577-579) . Furthermore section (4)(a) also expands section 96(2)(g) so that licence conditions can be modified to enable, promote and secure co-operation not just amongst NHS health service providers, but also between NHS bodies as defined in section 72 of the NHS Act 2006 and local authorities.

System governance

While the Bill specifies governance arrangements at ICB and ICP level, guidance puts forward expectations regarding governance structures within the system. There is an expectation of alignment between the constituent elements of ICSs.

For example, ICBs governance and constitution should align with that of ICPs (NHS England and Improvement, 2021). In relation to provider collaboratives, ICBs and provider collaboratives are expected to 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 (NHS England and Improvement, 2021). It is expected that the most senior leaders of the member organisations should come together to agree objectives and priorities for their provider collaboratives, and these must be consistent with those of the ICS(s) they serve as well as the wider system, including place-based partnerships (NHS England and NHS Improvement, 2021b). Provider collaboratives are also expected to agree specific objectives with ICSs (ibid.). NHS England and NHS Improvement will not prescribe the membership of individual provider collaboratives (although regional teams will retain oversight), but it will be up to providers and their system partners to decide together which provider collaborative arrangements, including membership, create the best opportunities to deliver the full range of expected benefits of scale (ibid.).

In terms of place based arrangements, NHS England and NHS Improvement have asked ICSs to confirm their initial proposals for place-based arrangements for 2022/23 onwards (NHS England and NHS

Improvement and Local Government Association, 2021). These arrangements should be mutually agreed between the NHS, local government and other system partners, and should set out: the configuration, size and boundaries of the ICS's places, the system responsibilities and functions to be carried out at place level, the planned governance model, including membership, decision-making arrangements, leadership roles as well as agreed representation on, and reporting relationships with, the ICP and ICB (ibid.). Membership for place-based partnerships is not specified nationally, however guidance encourages places to consider how they will include representation from primary care provider leadership, providers of acute, community and mental health services, including representatives of provider collaboratives where appropriate, people who use care and support services and their representatives including Healthwatch, local authorities, social care providers, the voluntary, community and social enterprise sector (VCSE), and the ICB (ibid.) Governance and decision-making should clear and proportionate, avoiding duplication across the ICS. Each ICB should set out the role of place-based leaders within its governance arrangements (NHS England and Improvement, 2021).

In relation to the delegation of functions, NHS England expects ICBs to publish a Scheme of Reservation and Delegation (SoRD) which sets out (i) functions that are reserved to the board (ii) functions that have been delegated to an individual or to committees and sub committees (iii) functions delegated to another body or to be exercised jointly with another body (NHS England and Improvement, 2021). ICBs are also expected to develop a functions and decision map - a high-level structural chart that sets out which key decisions are delegated and taken by which parts of the system, including any decision-making responsibilities that are delegated to other committees such as place-based partnerships and provider collaboratives (ibid.).

Additionally, guidance suggests the models ICBs may adopt to delegate functions. For example, 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 (NHS England and Improvement, 2021). 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). Guidance identifies five board types of governance arrangements that could be established to support place based partnerships to make decisions between the appropriate partners to support the aims of the partnership (NHS England and NHS Improvement and Local Government Association, 2021). These are: 1) a consultative forum which acts in an advisory capacity; 2) the delegation of functions to individual members of staff; 3) a committee of a statutory body provided with delegated authority to make decisions about the use of resources. A delegated budget can be set to describe the level of resources available to cover the remit of the committee; 4) a joint committee between partner organisations which delegate defined decision-making functions. A budget may be defined to provide visibility of the resources available to deliver the committee's remit; 5) a lead provider contract with the ICB and/or local government, having lead responsibility for delivering the agreed outcomes for a defined set of services.

4. Implications

In general, the proposals of the Bill regarding the governance of ICBs and ICPs allow great potential freedom and flexibility in terms of governance arrangements. The proposals mirror those contained in *The White Paper*. The Bill proposes legislation which will provide a small set of consistent requirements for each system, which acts as supportive scaffolding to enable the system to supplement with further arrangements and agreements that suit them, giving enough flexibility to reflect the local context.

Alongside the potential for local freedom and flexibility, there is potential for significant central influence over local governance arrangements. Under the proposals of the Bill, NHS England has significant scope for intervention in governance arrangements, for example power to review all aspects of the ICB constitution, decide whether they are 'appropriate' and intervene if not. Additionally, guidance from NHS England indicates further scope for central oversight of local governance arrangements. These guidance documents give 'clear but broad expectations'(DHSC and NHS England and Improvement, 2021) about local interpretations of the Bill. In some instances guidance lays out specific requirements in relation to governance. For example, NHS England has asked ICSs to confirm their initial proposals for place-based arrangements, and will have oversight of provider collaborative membership.

The degree of intervention which may result from this oversight is not clear, and has implications for the degree of hierarchical control which will be exerted over local governance arrangements in practice. While significant potential freedom and flexibility is proposed for ICSs in the Bill, it is also the case that the degree of central control which will be exerted over governance arrangements in practice is uncertain.

The constitution of the ICB

The proposals of the Bill in relation to the constitution of the ICB are minimal, allowing for local design of arrangements to best reflect the local context and substantial variation in local constitutional arrangements.

Regarding membership of the ICB, the minimal membership stipulated in the Bill of one member from each of NHS Trusts/FTs, primary care, and local authorities, has been increased in guidance to include five additional required members. While the size of ICB membership is unspecified in the Bill, these additionally specified members indicate that ICBs will as a minimum consist of 10 members (CEO, Chair, 3 x 'ordinary' members, Director of Finance, Director of Nursing, Medical Director, 2 independent Non-Executives). Local ICBs have freedom to increase the membership, with potential to include other members such as from the VCSE sector. The widening of membership of ICBs beyond statutory partners is not without controversy. Notably, the possibility that members could be drawn from the private sector has raised concerns in some quarters (Health Service Journal, 2021). Notwithstanding these issues arguably there are limits to how large the Board can become and still function an effective decision-making body.

The role of ICB members is a significant issue, particularly in in the light of concerns about undue influence, such as have emerged regarding the prospect of ICB members drawn from the private sector, and given the limited membership of the Board, whereby organisational partners and/or some professional groups may not be directly represented. Within the Bill the role of ICB members is not specified, but policy documents *(NHS England and NHS Improvement, 2021a, NHS England and Improvement, 2021)* contain guidance indicating that 'ordinary' board members are expected to bring knowledge and a perspective from their sectors, but not act as delegates of those sectors, or indeed of their individual organisations. This neutrality may be difficult to achieve in practice, particularly without stringent procedures to deal with conflicts of interest (see below). If this neutrality does not emerge in practice, there is the potential for actual or perceived undue influence, and/or imbalances of influence amongst local partners (if membership from a particular sector is increased).

Conflicts of interest

Guidance relating to the management of conflicts of interest in system decision making indicates that it should not be assumed that statutory NHS providers, local authority and primary medical services (general practice) are personally or professionally conflicted just by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations. However the potential for conflict of interest is high, both in the ICB and when the commissioning functions of the ICB are exercised elsewhere as NHS organisations are being tasked with making strategic decisions which concern themselves, and have implications for the flow of resources to their organisations. NHS providers will continue to have obligations to maintain their own financial viability as well as a role in strategic planning. It is likely that the imperatives associated with these two functions will not always coincide. It is also the case that there could be private sector providers on ICB committees or subcommittees making decisions about NHS funds.

The proposals in the Bill regarding the management of conflict of interest rest on the declaration of interests. The arrangements to manage conflicts of interest and to secure transparency about the decisions of the board and the manner in which they are made are left to local discretion. In the case of CCGs, Audit Office reports found minimal requirements of this nature to be unsatisfactory, and consequently NHS England issued statutory guidance to support the understanding and management of conflicts of interest among commissioners; enable commissioners to act fairly and transparently in the best interests of their patients and the local population; and maintain public confidence in the NHS, with guidance on how to identify and manage conflicts of interest (NHS England, 2016). Existing NHS guidance aimed at NHS organisations (NHSE, 2017) frames interests from an individual, rather than organisational, perspective and many of the approaches suggested are not appropriate in relation to decisions taken by the ICB or delegated elsewhere as it is to be expected that many decision makers will have organisational level conflicts of interest .

Furthermore, PRUComm research found that the guidance on managing conflicts of interest published by NHSE needed to be even more precise and less ambiguous to ensure more consistency both within and between CCGs (Moran V, 2017). Arrangements to deal with such conflicts are unlikely to need to be sensitive to local contexts. It is possible that locally specified arrangements will be insufficient to manage conflicts of interest appropriately in order to assure the public, providers and Parliament of the fairness and robustness of ICB decisions and that they are transparent and offer value for money. Furthermore it is possible that standards will differ significantly between ICBs.

Decision making inside the ICB and ICP

The limited size of the Board, combined with the potential delegation of any function of the ICB to committees and subcommittees, places great importance on the governance arrangements at committee and sub-committee level. These arrangements are not subject to specification in the Bill. In light of the collaborative approach to decision making and the principle of subsidiarity, it is to be expected that the exercise of ICB functions and decision making will be diffuse and many decisions will be made at a level not referred to in the legislation.

There are a number of implications relating to this.

Firstly, there is a great deal of freedom regarding who will be party to delegated decisions. Committees/sub-committees may include members who are neither members of the ICB, nor its employees. Potentially therefore there could be private sector providers on ICB committees or subcommittees making decisions about NHS funds. It is also possible that local stakeholders, such as Local Authorities, may not be party to decisions which affect their services.

Secondly, identifying the best location for functions and decisions may be complex. For example, functions and decisions may overlap where a decision regarding the provision of mental health services spans both provider collaboratives and place based partnerships. Past experience of initial under-specification of governance processes in the NHS (specifically the establishment of CCGs in 2013, see (Checkland, 2013)) demonstrates that it will be necessary for NHSE to ensure sufficiently robust constitutions are adopted where ICB decisions are being taken in forums other than the ICB itself, such as in place based committees. The functions and decisions map is intended to remain high level however in addition to the commissioning function of ICBs, there are other roles which CCGs fulfilled which will need to be accommodated elsewhere in the system[2], and will need to be adequately documented to ensure transparency.

Collaborative working and unity of purpose

There are a number of provisions to strengthen collaborative working in the Bill. Some of these place a duty on bodies to collaborate (the duty to co-operate and the Triple Aim) and others remove barriers to collaboration (freedoms to make joint appointments and flexibilities concerning the joint exercise of functions, by which ICBs, NHS Trusts and NHS FTs may arrange for functions to be exercised by or jointly with other ICBs, Trusts, FTs as well as local authorities).

Duties for organisations to co-operate with each other have been in place previously. The NHS Act 2006 gave all NHS bodies, including Foundation Trusts, a statutory duty to co-operate with each other

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[2] Some examples of these are: liaison between primary, secondary, community and local authority services to ensure that changes proposed in one part of the system do not adversely affect other; the provision of high quality general support services such as contracts for sample collection from local provider sites, an overview of local estates, local support for organisations struggling due to staff sickness; the quality assurance and management of small contracts, such as for example for specialist mental health projects.

(NHSA 2006, s72). However the Bill importantly extends this to local authorities. The exact nature about what this duty will mean in practice is currently unspecified, and the Explanatory Notes suggest that new guidance will give organisations greater clarity about what the duties to cooperate mean in practice.

In the light of the lack of direct control of the ICB over providers, it is not clear whether the strengthening of duties to collaborate will be sufficient to ensure that the ICB will have sufficient sway over providers in practice if they are not inclined to co-operate regarding shared decision making.

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