Guidance on the functions and governance of the integrated care board, and the model constitution

NHS England and NHS Improvement (NHSE/I) published several integrated care system (ICS) guidance documents and accompanying resources on 19 August to support systems' transition into statutory integrated care boards (ICBs) by 1 April 2022. These include:

1. *Interim guidance on the functions and governance of the ICB*
2. The model ICB constitution and supporting notes (NHSE/I ICS implementation hub)
3. A list of statutory clinical commissioning group (CCG) functions to be conferred on ICBs (NHSE/I ICS implementation hub)
4. *Building strong ICSs everywhere: guidance on the ICS people function*
5. Other guidance, including: an HR framework for developing ICBs, an ICB readiness to operate statement, and due diligence guidance (NHSE/I ICS implementation hub)

This briefing summarises these resources and provides detailed commentary on the ICB functions and governance guidance, model constitution and ICS people guidance. Please contact senior policy manager Georgia Butterworth (georgia.butterworth@nhsproviders.org) if you have any comments or questions.

Summary

- The *Interim guidance on the functions and governance of the ICB* summarises the indicative mandatory governance requirements for ICBs, as set out in draft legislation and NHSE/I policy:
  - Each ICB must set out its governance and leadership arrangements in a constitution for NHSE/I approval by the end of Q4, following an engagement process.
  - The guidance confirms the minimum requirements and current expectations regarding ICB board appointments and membership. For example, ICB designate chief executives must be identified by the end of November, and other ICB board roles confirmed by the end of Q4.
  - Systems are expected to develop a "functions and decision map" alongside the constitution, showing governance arrangements are in place within the ICB and with ICS partners.
  - The ICB board will be responsible for: formulating a strategy for the organisation; holding the organisation to account for the delivery of the strategy; and shaping a healthy culture for the organisation and wider ICS partnership.

  - The guidance also includes key considerations for system leaders as they design these arrangements, including for example managing conflicts of interest.
- The ICB functions and governance guidance document should be read alongside the model constitution and interim guidance on CCG functions to be conferred on ICBs:
  - The Health and Care Bill (the Bill) requires each ICB to have a constitution. NHSE/I has developed a template based on the CCG constitution to guide its development and associated consultation.
  - This model constitution covers the composition of the board, appointments process (including a nomination and selection process for partner members) and arrangements for remuneration.
  - The model constitution sets out further detail on how ICBs must ensure a balance of perspectives on the board (e.g. from all provider types) and in the ICB's decision-making process. We have been calling for this mechanism and are pleased to see it embedded here.
  - The interim guidance on CCG functions transferring to ICBs sets out the complete list of statutory CCG functions that NHSE/I expect to be conferred on ICBs in April 2022. The guidance also summarises actions that designate ICB leaders should take, with CCGs, to prepare to discharge their statutory functions as ICBs.
- The ICS people function guidance builds on the priorities set out in the People Plan and aims to support ICBs and their partners to deliver outcome-based people functions from April 2022.
- The HR framework provides practical support for CCGs as they transition to statutory ICBs. NHSE/I states that the ICS readiness to operate statement and checklist will support system leaders to assess progress and transition towards the establishment of ICBs. The due diligence guidance outlines legal processes in relation to the establishment of ICBs and the abolition of CCGs.

1. Summary of the guidance on ICB functions and governance

This interim guidance builds on the ICB governance arrangements outlined in the Bill and *ICS design framework*. The statutory instruments and guidance enabling the ICB and integrated care partnership (ICP) cannot be made formally until the Bill is enacted, which is expected in April 2022, so this interim guidance aims to support system partners to make the necessary preparations. It confirms the 'must do' requirements (subject to legislation) and sets out key considerations to inform local discussions on the design and implementation of ICBs and ICPs (see Annex 1).

NHSE/I expects system leaders to use the guidance and accompanying resources to inform aspects of their transition to statutory organisations in April 2022, including:

- The development of the ICB constitution, following engagement with relevant partners and confirmation that ICB designate board members are supportive of its terms, with a final version being approved by NHSE/I by the end of Q4.
- ICB board recruitment, with designate chief executives identified by November; a designate finance director, medical director, director of nursing and other executive roles in the ICB identified before the end of Q4; and designate partner members and any other designate ICB senior roles identified by the end of Q4.
- Commissioning functions organised across the ICS footprint, with decisions on arrangements at system and place level being finalised by the end of Q3.
- Functions and decision map showing arrangements within the ICB and with ICS partners, with a final version due before the end of Q4.

NHSE/I expect the core components of the ICB governance arrangements to include:

- A statutory committee called the ICP, with the expectation that each ICB will need to align its constitution and governance with the ICP. The guidance highlights the key role of ICPs, as set out in the *ICS design framework*, and refers to new ICP guidance that will be issued by the Department of Health and Social Care, in partnership with NHSE/I and the Local Government Association.
- A statutory body called the ICB, with the expectation that each ICB will need to put arrangements in place to ensure they can effectively discharge their full range of duties and functions. The guidance references the 12 key functions of the ICB as outlined in the *ICS design framework*.
- Place-based partnerships, with the expectation that ICBs will be able to arrange for decisions to be made by/with place-based partnerships, with the ICB remaining accountable for NHS resources at place-level. Each ICB should therefore set out the role of place-based leaders within its governance arrangements.
- Provider collaboratives, with the expectation that provider collaboratives agree specific objectives with one or more ICB, as highlighted in NHSE/I's recent guidance (August 2021).

NHSE/I notes that this is not an exhaustive list and states that systems will want to consider a much wider range of governance vehicles to conduct their business.

ICB commissioning functions

From April 2022, the statutory functions that currently sit with CCGs will be conferred on ICBs, along with staff, assets and liabilities (including commissioning responsibilities and contracts). Relevant CCG duties will be transferred, including those regarding health inequalities, quality, safeguarding, children

in care and children and young people with special educational needs or disability. The full expected list of CCG functions to be conferred has been published (see summary in section 3 below).

NHSE/I reiterates the intention to delegate some direct commissioning functions to ICBs as soon as operationally feasible from April 2022. NHSE/I wrote to trusts in July setting out these changes. Statutory ICBs will also have the flexibility to deliver commissioning activities differently e.g. with providers/local authorities, subject to legislation.

Decision-making within an ICB

With regards to decision making, NHSE/I expects ICBs to publish a scheme of reservation and delegation which sets out:

1. Functions that are reserved to the board
2. Functions that have been delegated to an individual or committees/sub committees
3. Functions delegated to another body or to be exercised jointly with another body

ICBs must also develop a functions and decision map that:

- Is locally defined
- Sets out where decisions are taken
- Outlines the roles of different committees/partnerships
- Is easily understood by the public

Board of the ICB, including membership, remuneration and committees

The guidance provides a list of the minimum membership of the unitary board of the ICB, which reflects the list in the *ICS design framework*. It also outlines the unitary board's key responsibilities as:

- Formulating a strategy for the organisation
- Holding the organisation to account for the delivery of the strategy
- Shaping a healthy culture for the organisation and the wider ICS partnership

The guidance makes clear that ICB executives will be employed or seconded to the ICB and will be paid as employees. Independent chairs and non-executive members will be remunerated for their time (in line with forthcoming NHSE/I guidance). The legislation will also allow for the 'partner' members to be remunerated where relevant. The board will decide remuneration for board members not employed by the ICB, but all bodies should ensure no members are paid twice for the same time by different organisations.

The guidance outlines the ways in which ICBs must demonstrate how they are driving equality, diversity and inclusion (EDI), ensuring for example that: the workforce represents the diversity of the NHS; the culture promotes inclusion and embraces diversity; and employees and board members display inclusive behaviour.

The guidance outlines the fact that the legislation is expected to require all ICBs to establish an audit committee and a remuneration committee, as well as giving ICBs the power to appoint individuals who are not board members or ICB staff to be committee members and to delegate its functions to be exercised by or jointly with partners e.g. trusts, local authorities, other ICBs, or NHSE/I.

ICBs will have statutory duties regarding the management of conflicts of interest, including maintaining one or more registers for board members, committee members and employees. The guiding principle for any conflict of interest policy is to ensure that decisions are made in the public interest by avoiding any undue influence. ICB boards are encouraged to set aside the necessary time to debate and explore these issues as part of their developmental journey.

NHS Providers view

This interim guidance document on ICB functions and governance begins to build on the requirements set out in the *ICS design framework* (June 2021) and the Health and Care Bill (as introduced in July 2021). It provides some further clarity on the role and responsibilities of the ICB, while leaving scope for the ICB and its constituent organisations to determine local governance infrastructures. We support NHSE/I's intention to maintain a permissive framework for systems and will engage with trust leaders to assess whether this guidance enables sufficient local flexibility for systems to continue designing what works best for their local populations, services and circumstances. As the new ICS model evolves, the guidance will also need to be adaptable in the context of any issues that may arise.

Trust leaders and their local partners are already involved in many different forms of collaboration, which all aim to improve services and patient care, and deliver efficient use of resources, in a similar vein to the new Triple Aim policy which will be implemented through the Bill. Trusts and their partners are already designing, delivering and overseeing collaborative strategies, and managing risk effectively, in the absence of the ICB structure. Systems and NHSE/I national and regional teams must continue to acknowledge this reality and work with it, rather than create a whole separate ICB governance infrastructure. Building on what works in existing ICS governance, and keeping focused on the purpose and aims, will be crucial to the success of system working.

We have engaged extensively with NHSE/I in the design of ICBs, including emphasising the importance of the full range of provider types having sufficient access and input to the ICB decision-making process. While we welcome the requirement in the model constitution on ICBs to establish a mechanism which enables the views of trusts to feed into ICB decisions, this ICB governance guidance only states that the constitution must confirm that ICB board members are supportive of its terms; it does not explicitly require the ICB to ensure all trusts and wider partners are involved in the development of the constitution and/or supportive of its terms, nor provide recourse to a challenge function in extremis. If the ICB is not established by its constituent organisations, it risks setting up a divisive culture in the system. This risk is exacerbated by the articulation of ICBs as separate bodies to their constituent organisations, rather than being a sum of their parts. The ICB needs to be accountable to its local populations and constituent organisations to realise its ambitions.

We support the principles of subsidiarity, minimal bureaucracy and clear accountabilities as set out in Annex 1 to inform the design and development of local system governance arrangements. We also support the focus on ICBs demonstrating how they are driving EDI throughout the system, and the emphasis on the ICP challenging all partners to demonstrate progress in reducing inequalities and improving outcomes. NHSE/I regional teams will need to support systems to develop clear decision-making arrangements and accountabilities. The guidance refers to ICB boards not only formulating the strategy for the organisation but also holding the organisation to account for the delivery of the strategy. It also states that provider collaboratives will agree specific objectives with one or more ICB, and agree how to achieve those objectives, but the ICB will be accountable. These complex arrangements will be challenging for trusts and their partners to navigate and avoid overlapping, unclear accountabilities.

Another challenge for ICBs and their constituent organisations will be how to manage conflicts of interest. While trusts and their partners already navigate these challenges, the new provider selection regime and collaborative approach to decision-making will make contracting and commissioning decisions more complex. We look forward to continuing to work with NHSE/I and partners to explore these outstanding questions and concerns in more detail.

2. Model constitution and supporting notes

NHSE/I has developed a model constitution – based on the current CCG constitution – for system leaders and CCGs to guide the development of, and consultation on, their ICB constitution. The

model constitution is based on the proposed requirements as set out in the Bill. The constitution will need to be updated in line with any changes to the legislation and NHSE/I policy.

The ICB can apply to the newly merged NHSE to vary the constitution (NHSE/I will publish an application procedure), or NHSE can vary the constitution under its own initiative. The constitution should set out a local procedure for who may propose a change to the constitution and how this is done, who will be consulted on any proposed changes, and how the decision about proposed changes will be taken prior to an application being made to NHSE (typically this will be the ICB board).

The supporting notes accompanying the model constitution suggest content beyond the legal requirements (as currently drafted) of what needs to be included in the ICB constitution, for example:

- Explaining how the ICB differs from CCGs, and drawing out mutual accountability arrangements;
- Referring to how this constitution aligns with the ICP's terms of reference; and
- Clarifying that ICBs may decide to have more than one 'ordinary member' from each sector, and more than two independent non-executive members, beyond the statutory minimum and NHSE/I policy requirements.

Composition of the board of the ICB

The constitution of the ICB must set out board roles and membership and ensure a balance of perspectives on the board. For example, the ICB must ensure that the perspectives of all sectors and types of provider within the ICB's area are included (e.g. acute, mental health, community and specialist). ICBs will need to ensure that the views of patients, carers and the public are heard and included in the board decision-making process, along with clinical and professional groups. Beyond the composition of the board itself, ICBs should ensure there are mechanisms for including the full range of perspectives through its decision-making model and structures. ICBs will also be expected to comply with good governance practices, including on board size, to allow appropriate decision-making to take place. The constitution recommends limiting the number of participants as most parties will play their largest role in the partnership or in operational fora and task and finish groups.

Appointments process for the board

The constitution of the ICB must set out board roles, the process of appointing partner members and eligibility criteria that must be fulfilled. Each member of the ICB must:

- By law be subject to the chair's approval (excluding the chief executive who is approved by NHSE/I)
- Comply with the criteria of the fit and proper person test
- Be willing to uphold the Nolan Principles
- Fulfil the requirements in the role specification
- Meet the eligibility criteria set out in the constitution (some nationally and some locally defined)

The constitution will also set out the appointments process for ICB board members, including the terms and number of terms permitted. NHSE/I will publish a process to describe how chairs and chief executives will be appointed, and how appointments proposed by ICBs will be approved.

The Bill states that the partner members are to be 'nominated jointly' by their respective sector. The constitution must set out the appointment process of partner members, including who may take part (regulations will set out which organisations can take part in any nomination process), what the procedure entails and what the decision-making arrangement is. The process should reflect NHSE/I guidance. As a minimum, it must include two parts:

1. An element that is designed to build the confidence of stakeholders that the perspective of the individual will contribute to the board discussions (the nomination process).
2. An element that is designed to assess that the individual can demonstrate they have the skills, knowledge, experience and attributes required to fulfil the role (the selection process).

The partner member from the trust sector will need to be an executive director of a trust within the ICB's area. The *ICS design framework* states this will often be the chief executive.

While the ICB board should normally include medical/nursing/finance director roles, NHSE/I recognises they may be fulfilled in different ways, such as by different job titles or holding other responsibilities with a wider portfolio. They may be an employee of another organisation as well as the ICB. The medical director must be a registered medical practitioner.

ICBs may choose to appoint more than the minimum requirement of two independent members. It is good practice for one independent member to be appointed as a senior independent member. The ICB may want to add other local criteria, such as requiring non-executive members to have a connection to the ICB area. The ICB should consider whether individuals who have served in equivalent roles on the boards of previous and current NHS bodies locally could be sufficiently independent. The chair's terms of appointment will be determined by NHSE/I.

Arrangements for remuneration will be agreed by the remuneration committee in line with the ICB's policy and any NHSE/I guidance. Remuneration for chairs, non-executives and chief executives will be set by NHSE/I. The duties of the remuneration committee will be locally determined, such as setting the ICB pay policy and setting remuneration for board members.

Generally, it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required, and the constitution will set out the process for voting (which should be considered a last resort).

Arrangements for the exercise of ICB functions

The ICB may grant authority to any of its members/employees or a committee/sub-committee to act on its behalf. The ICB may also arrange for functions to be exercised by a joint committee or enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund. The ICB remains accountable for all its functions, including those it has delegated, so the constitution should describe local arrangements for assurance. ICB committees may include or be formed from individuals who are neither employees of nor board members of the ICB.

Arrangements for conflict of interest, accountability and transparency

The ICB will be required to manage actual and potential conflicts of interest to ensure the integrity of the ICB's decision-making processes. For example, where independent providers hold contracts for services, NHSE/I sees it would be appropriate for the ICB to involve them in decisions, such as about pathway design at place level, but this would be distinct from contracting and commissioning considerations. NHSE/I may issue guidance for ICBs in due course, but ICBs should follow NHS-wide guidance for now. ICBs may choose to appoint a conflicts of interest guardian.

The ICB will demonstrate its accountability to local people, stakeholders and NHSE/I. Board and committee meetings will be held in public, with papers and minutes published. The ICB will comply with the requirements of the NHS provider selection regime and ensure there are appropriate governance structures that will deal with any challenges following decisions. ICBs will need to publish their intentions for arranging services in advance, publishing contracts awarded and keeping records of decision-making.

NHS Providers view

We welcome the publication of the model constitution for ICBs as a helpful means of supporting systems to prepare for their transition to statutory bodies in April 2022. Creating template documents that can be adapted locally is helpful for systems and their constituent organisations to avoid reinventing the wheel. The Bill includes a lot of detail as to what must be in the ICB constitution, so while we support NHSE/I's intention to enable maximum local flexibility, we are conscious there is little latitude for NHSE/I to streamline the statutory requirements. We will continue to engage with trust leaders on how emerging frameworks and guidance documents are carrying through the ambition of local flexibility to implementation.

We welcomed the opportunity to feed into the development of the model constitution and are pleased to see that much of our feedback has been incorporated in this final draft. In line with our feedback, the model constitution provides some helpful precision about the nature of the unitary board and clarity about the ICB's powers, including making delegations and being accountable for all delegated decision-making. It also clarifies the role of the ICB board and senior independent member. We look forward to continuing to work closely with NHSE/I to develop a clear policy framework for ICBs and their constituent organisations.

Constitutions should be used by boards as tools to assist them in the governance of their organisations and should also act to assure stakeholders that appropriate governance infrastructures are in place. Constitutions need to be adaptable to local conditions and changing circumstances, as well as able to change provisions that do not work well in practice. The Bill includes a provision that constitutional changes submitted by ICBs will not take effect until approved by the newly merged NHSE. It is important therefore that NHSE is able to approve proposed constitutional changes promptly through a simple process and should confine its role to ensuring that any proposed changes are lawful.

One of our priority concerns on behalf of trust leaders is the importance of ICB boards taking account of the views of key stakeholders, particularly constituent organisations within the ICB area, in making decisions. We therefore welcome the emphasis in the supporting notes on ensuring a balance of perspectives on the board of the ICB, including all sectors and types of providers. We have also called for a mechanism to include this full range of perspectives through the ICB decision-making structures and welcome this requirement in the supporting notes. These arrangements will be crucial to sustaining the ICS as a sum of its parts, and we urge NHSE/I to apply this consultative focus consistently, including in the establishment of the first constitution and any subsequent amendments.

The role of non-executive board members will be crucial on the ICB, facilitating strong challenge and assurance at board level. Trust leaders have stressed the need for non-executives to form a majority on the board, and we will continue to call for this to be adopted as best practice. While the model constitution emphasises consensus decision-making, it is important for ICBs to welcome effective challenge and well-reasoned dissent. Trust leaders will also want to consider how their organisation's non-executives could be linked into the new ICB governance infrastructure.

We remain concerned about the ICB chair being appointed (and possibly removed) by NHSE/I with approval from the Secretary of State for Health and Social Care, and no involvement of the ICB members or wider system partners. This is concerning as the chair needs to have the confidence of the ICB and system partners. We urge NHSE/I to ensure a significant role for these bodies in the recruitment of the chair, even if powers of appointment lie elsewhere, and include a description of the chair's independence in the handbook referenced in the supporting notes.

3. List of statutory CCG functions to be conferred on ICBs

This document forms part of the ICB functions and governance guidance. It sets out a list of current CCG statutory functions that will be conferred on ICBs, subject to the Health and Care Bill being passed. NHSE/I expects most CCG statutory functions to be conferred on ICBs in April 2022, along with the transfer of all CCG assets and liabilities. Some functions and duties may be amended or strengthened.

The guidance also summarises actions that designate ICB leaders should take, with CCGs, to prepare to discharge their statutory functions as ICBs. NHSE/I expects ICS/ICB leaders to work with CCGs through the list of statutory functions in the document to ensure responsibility for each function is clear within their proposed new ICB arrangements and that the ICB will have the capacity to carry them out effectively. This includes deciding what statutory functions should be delivered at ICS or place level – this will be for local determination. The Bill also makes provision for ICBs to delegate certain functions to trusts, but ICBs will still be held to account for the discharge of these functions. There will be some functions that ICBs will not be able to delegate to providers e.g. managing conflicts of interest.

4. Building strong ICSs everywhere: guidance on the ICS people function

The ICS people function guidance builds on the themes and priorities set out in the NHS people plan, published in July 2020, helping to set a framework for the consideration and undertaking of workforce activity at system level. The document clarifies how partners within an ICS are expected to contribute to this, but does not seek to describe "the full breadth of ICS workforce arrangements". It sets out priorities for the remainder of this financial year, points towards requirements for greater collaboration over resource decisions at system level from April 2022 (which will require further guidance) and provides a relatively detailed steer on the type of responsibilities trusts and other partners may consider for delivery at system level.

The document makes it clear that NHSE/I "does not prescribe a 'one size fits all' approach to establishing, developing and delivering the ICS people function". On the contrary, this guidance has been produced with an intention to "support local flexibility", recognising that systems will have different approaches and existing levels of collaboration on workforce activity, and that each ICS will need to proceed in a manner chosen "according to their particular circumstances".

Priorities for action: 2021/22

While some systems will be more 'advanced' towards undertaking a greater level of workforce activity at ICS level, the guidance prescribes a small but significant list of immediate 'preparatory' actions for system leaders and partners within the ICS as part of establishing the people function. They are asked to:

1. Agree the formal ICB and ICP governance and accountability arrangements for people and workforce in the ICS, including appointed SROs;
2. Agree how and where specific people functions are delivered within the ICS (for example, ICB, provider collaborative, place-based partnership);
3. Review, refresh or establish (where not in place) the ICS People Board in line with wider ICS governance and accountabilities, with clear reporting arrangements into the ICS Board; and
4. Assess the ICS's readiness, capacity and capability to deliver the people function, by identifying gaps and developing the necessary infrastructure to address these.

NHSE/I encourages system leaders and partners to utilise its System Development Progression Tool, among other resources, to support this process.

Principles and ambitions of the people function: from April 2022

Within the guidance, NHSE/I had created "10 outcomes-based functions", which could be described as overarching principles and ambitions for the workforce within each ICB. These ten broad workforce priority areas will form the basis on which system leaders and partners seek to make their areas better places to work for staff:

1. Supporting the health and wellbeing of all staff
2. Growing the workforce for the future and enabling adequate workforce supply
3. Supporting inclusion and belonging for all, and creating a great experience for staff
4. Valuing and supporting leadership at all levels, and lifelong learning
5. Leading workforce transformation and new ways of working
6. Educating, training and developing people, and managing talent
7. Driving and supporting broader social and economic development
8. Transforming people services and supporting the people profession
9. Leading coordinated workforce planning using analysis and intelligence
10. Supporting system design and development

These 'functions' align very closely with the priorities of the people plan and the document provides a chart of intended outcomes, overarching ICB responsibilities within the functions, and a set of potential (non-mandatory) workforce activities that could be delivered at system level to meet the stated ambitions.

From April 2022, ICBs will be expected to coordinate and allocate the resources required to enable delivery of the people function, with buy in from all constituent partners within the system and with support from national and regional teams.

"One workforce" and principles of subsidiarity

The guidance contains a strong focus on a "one workforce" approach within ICBs, urging system leaders to consider where activity at scale can have the greatest impact for local communities. It emphasises that the ICB will hold responsibility for clinical and non-clinical staff working in primary and community care (alongside secondary and tertiary care), and that ICBs will be expected to support and collaborate with those who provide wider community services, including in local government, other public services and in the voluntary sector.

However, the document makes clear that the principles of subsidiarity will be applied to staff support and workforce management, noting the many advantages (and necessities) of workforce activity

carried out 'below' system level, whether by provider organisations, primary care networks, at place, or through provider collaboratives.

The guidance states that individual organisations within as system will continue to have direct responsibility for the staff in their own organisations. Further clarification is provided on the type of activity carries out at regional level and by national NHS bodies as well, with an emphasis on the continued responsibility of the seven regional people boards to support the identification and delivery of at scale work within and across ICBs.

NHS Providers view

The ICS people function guidance will provide a useful reference point for trusts as many seek to work more closely with system partners on workforce issues, and indeed on the delivery of key workforce activity across wider footprint areas. During the development of this guidance (and the HR framework discussed below), trust leaders have sought clarification on the question of 'who will do what' when it comes to staffing issues, particularly given the steer from NHSE/I to set up ICBs as the primary forum for workforce planning in the NHS. This aim for workforce planning is yet to happen in many places, so – while the maturation of regional people boards have certainly aided progress – trust leaders will be pleased to see the guidance contains a clear message around individual organisations retaining responsibility for their employed staff, and will largely support the absence of a 'one size fits all' approach to delivery of workforce activity at system level.

We welcome the focus on developing infrastructure for the ICS people function in the short-term and support the emphasis on building effective governance structures while assessing readiness for system-level delivery. While the guidance helps to provide a framework for realising the benefits of workforce activity at scale, it is crucial not to lose sight of the ever-present barriers to achieving this, not least the very large and persistent workforce gaps facing the service, which can limit the ability of staff to work more flexibly across organisational boundaries. Current operational pressures will also constrain trust leaders and people professionals in their efforts to speedily put new, legally binding policies in place and form effective collaborations with system partners to implement them.

5. Other guidance documents for ICBs

HR framework for developing ICBs

NHSE/I has developed an HR framework to support CCGs and ICSs as they develop and transition towards the new statutory ICBs. It reiterates NHSE/I's ambitions to provide employment stability and

ensure a safe and effective transfer of staff, as well as giving guidance on how to manage the transition. All staff below board level will 'lift and shift' from one organisation to the other, to minimise disruption. All board-level staff will not be covered by the employment commitment and will be affected by the need to establish designate executive ICB roles. There is some flexibility built into the framework around which roles are considered board level.

ICB readiness to operate statement and checklist

This guidance is intended to support existing ICS leaders, and designate ICB leaders as they are appointed, to prepare for the legal and operational establishment of ICBs and abolition of CCGs on 1 April 2022. It includes a template ICB readiness to operate statement (ROS) and accompanying checklist. It describes how the checklist will be used to support preparations for, and assess progress towards, the establishment of ICBs. Key actions from the guidance include:

- The requirement for each designate ICB CEO and their relevant regional director to co-sign the ROS in March 2022. The ROS is a high-level statement to confirm that all critical elements are in place ready for the establishment of the ICB on 1 April 2022 and arrangements are in place for the ICB to fulfil its role within the wider ICS.
- Reporting on progress against the ROS checklist at the end of Q2 and Q3 2021/22 and in mid-February 2022. The checklist reflects core elements in the *ICS design framework* as well as the due diligence activities needed to prepare for the duties of CCGs to be transferred to ICBs.

Due diligence, transfer of people and property from CCGs to ICBs, and CCG close down

This guidance is to support CCGs and ICSs to transition effectively to ICBs. The guidance sets out the definition of due diligence and the planning processes involved in ensuring an effective transfer of CCG duties. It also covers information on the legal documentation and process for abolishing CCGs and closing down activities. The key actions from the guidance include:

- CCG accountable officers ensuring that their teams plan for and undertake robust and proportionate due diligence, making use of the due diligence checklist (on the NHSE/I ICS implementation hub).
- In March 2022, CCG accountable officers should provide written assurance of due diligence to the relevant NHSE/I regional directors and (if appropriate) the designate ICB chief executive.