Bevan Brittan

Interim guidance on Functions and governance for Integrated Care Boards[1]

NHSE has stepped up the production of guidance on various issues that local systems will need to organise for the anticipated date of going live for Integrated Care Boards of 1 April 2022. However, whilst there is a need to move ahead with preparations given the scale of the governance work required to establish and formalise arrangements for April there is a problem- the Health and Care Bill has only now started its Committee stage in the House of Commons, and it seems unlikely to progress to the Lords before mid-November at the earliest. We don't know how far changes will be accepted in the drafting, and while steps can be taken in preparation, there will also be a pressured period after the Act is finalised to get formal agreements in place for all the different parts of the new structures.

Each ICB will need to have its own constitution, and importantly this will need to set out how it makes decisions, including through relevant committees, and the expectation is that the ICBs will publish their schemes of delegation.

There will also need to be changes in Council constitutions to cater for the development of the Integrated Care Partnerships (ICPs) as joint committees, and there are open questions about the ability of Local Authorities to delegate executive functions to ICPs, as there have been over Health and Wellbeing Boards. Provider collaboratives may also need to refine their structures to ensure appropriate linkage to the ICB structures, PCNs and the social care provider operators.

Place based partnerships (as NHS England describe the Place layer of ICBs) will also need to be given an appropriate form and the guidance makes suggestions of what NHS England might approve in relation to this, although the detail will need to be worked out locally in the light of the emerging statutory controls particularly over joint working arrangements. There is also much work to be done on the provision of guidance by both the Secretary of State and NHS England.

There are also some points to note from the guidance which reflect the developing thinking on this:-

- Although the Bill includes provision for the transfer of primary care commissioning functions outright to ICBs, the governance guidance makes it clear that initially this will not happen – we understand that part of the Bill will not be implemented immediately, and in the meantime delegation arrangements will continue, albeit under the new provisions which will allow for further delegations .
- The Guidance also restates the purposes of the ICBs harking back to the formulation used in the January 2021 paper. This included a fourth aim: to "help the NHS support broader Social and economic development". This does not however appear in the Bill as part of the functions of the ICBs, nor indeed is it a matter which ICBs must have regard to in exercising their functions. It is also odd that this does not appear in the 'Triple aim' of health and well-being of all, quality of care, and use of resources, which is now reflected in a duty to have regard to the wider implications of their decisions.
- Conflicts of interest are again a material feature both in the Bill and the guidance. Regrettably the guidance continues the blurring of the distinction between declaring interests, which is again required for all ICB staff and committee members, and the management of conflicts that may arise. There is still a degree of avoidance of the issues which arise over the presence on the Board itself of nominees of providers and the local authorities. There is some merit in adopting the approach in the Foundation Trust constitutions of allowing the Board to permit situational conflicts that may arise. This could allow, for example, Trust Chief Executives, who are also under a duty to act in the interests of their own organisation, to take more general decisions. Where an ICB is considering their funding or contract, it is difficult to see how allowing them to be involved in that type of decision does not fall within the definition of a conflict of interest. This will require careful management.
- Another area of potential concern is the differential treatment of different types of provider. Trusts and primary care clinicians are clearly treated as part of the combined process, as are the voluntary, community and social enterprise sector. Otter providers are outside the structures, and very much kept at arm's length. This may create problems where private providers are playing a material part in the local health and care economy (or want to be able to), and for example it seems odd not to have the main social care providers in the discussions on that part of the system. It is also less than ideal to exclude the private hospital sector from discussions around patient safety and quality of services post Paterson.

[1] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0886_Interim-guidance-on-the-functions-and-governance-of-the-integrated-care-board-August-2021.pdf