

BOARD MEETING

Title	Future of ICBs – update on role of ICBs within changing system landscape & Joint working across the South East		
Paper Date:	6 May 2025	Board Meeting Date:	13 May 2025
Purpose:	Discussion and Decision	Agenda Item:	10
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Executive Summary

Context

On 13 March, the government announced the abolition of NHS England and a streamlining and refocusing of Integrated Care Boards, including by reducing ICB costs by an average of 50%.

On 1 April 2025, NHS England Transition CEO, Sir Jim Mackey, wrote to Integrated Care Board (ICB) and provider leaders outlining how NHS England will work with leaders to deliver the core national priorities and lay the foundations for reform in line with these changes. The letter set out the critical role ICBs will play in the future as strategic commissioners, and in realising the ambitions that will be set out in the 10 Year Health Plan. As ICBs need to develop plans to reduce their costs by the end of May, NHS England also committed to clarifying the role of ICBs by co-producing a Model ICB Blueprint and sharing the functional output of this work.

Model ICB Blueprint

The Model Integrated Care Board (ICB) Blueprint was jointly developed by NHS England and ICB leaders from across the country and was shared on 2 May. The BOB ICB Chief Strategy, Digital and Transformation Officer was invited to join a national working group to develop the blueprint and worked closely with the national team to create the final product, drawing on work we have done in BOB.

We are sharing the document in our meeting today to support a collective discussion on the evolving role of ICBs as strategic commissioners within a reformed NHS landscape, in line with national reform priorities and the forthcoming 10 Year Health Plan. It is clear that moving forwards, ICBs will play a critical role in improving population health outcomes, reducing inequalities, through setting strategy and ensuring effective use of their resources to deliver maximum value for their population.

As set out in the CEO report, we are developing an ICB Transformation plan to describe how we will achieve the running cost requirement and deliver the Model ICB Blueprint. More detail on this will be provided as this work develops.

Working together at scale across the South East

The Model ICB Blueprint refers to examples of functional areas where ICBs may wish to come together at scale to deliver their functions and activities, working at pan-ICB level.

In the South East region, we have developed such working arrangements and the ICBs across the South East of England have come together to form the Collaborative South East ICBs Chief Executive Officers Joint Committee ('Joint Committee').

We are bringing the terms of reference of this committee and a further joint forum overseeing the delegation of specialised commissioning to Board for awareness and approval today.

The NHS ICB partner members across the South East are:

- NHS Frimley ICB ('Frimley ICB')
- NHS Buckinghamshire, Oxfordshire and Berkshire ICB ('BOB ICB')
- NHS Hampshire and the Isle of Wight ICB ('HloW ICB')
- NHS Kent and Medway ICB ('Kent & Medway ICB')
- NHS Surrey Heartlands ICB ('Surrey Heartlands ICB')
- NHS Sussex ICB ('Sussex ICB')

The Joint Committee, whose governance arrangements are described in these terms of reference, is the collective governance vehicle for joint decision-making by the ICB Partners.

Areas of working together at scale are proposed as:

- (a) Using a common approach for the Federated Data Platform (FDP) and to roll this out across the south east.
- (b) Reviewing and assessing commissioning of delegated services, including specialist commissioning, pharmacy, optometry and dentistry services to identify opportunities to collaboratively commission improved, high quality, modern, strategic clinical services. This will include forward planning for further areas of delegated commissioning in the future.
- (c) Culture and leadership: Developing a system approach for the south east ICBs; sharing risk and benefits, where this is beneficial to south east populations, as a whole. Creating the best possible culture and leadership for the south east.
- (d) Financial sustainability
- (e) Strategic and collaborative commissioning at scale: Focussing on:
 - i. the urgent and emergency care pathway to enable a collective approach to ambulance services
 - ii. a review of mental health services to improve care in a more consistent way for people with a mental health condition.

Following delegation of specialised commissioning to ICBs from April 2025, the Joint Committee also proposes a specialised commissioning sub-committee, the terms of reference for which are also attached for approval by the Board.

Action Required

The Board members are asked to discuss the contents of the Model ICB Blueprint, consider its implications for BOB ICB, and identify any areas for further clarification.

The Board Members are also asked to approve the Terms of Reference for joint working across the South East.

Conflicts of Interest:

No conflict identified

**Date/Name of Committee/
Meeting, Where Last Reviewed:**

N/A

Model Integrated Care Board – Blueprint v1.0

Introduction

On 1 April, we wrote to Integrated Care Board (ICB) and provider leaders outlining how we will work together in 2025/26 to deliver our core priorities and lay the foundations for reform. The letter set out the critical role ICBs will play in the future as strategic commissioners, and in realising the ambitions that will be set out in the 10 Year Health Plan. As ICBs need to develop plans to reduce their costs by the end of May, we committed to clarifying the role of ICBs by co-producing a Model ICB Blueprint and sharing the functional output of this work.

This Model ICB Blueprint has been developed by a group of ICB leaders from across the country, representing all regions and from systems of varying size, demographics, maturity and performance. It is a joint leadership product, developed and written by ICBs in partnership with NHS England. The group has worked together at pace to develop a shared vision of the future with a view to providing clarity on the direction of travel and a consistent understanding of the future role and functions of ICBs.

The delivery of the 10 Year Health Plan will require a leaner and simpler way of working, where every part of the NHS is clear on its purpose, what it is accountable for, and to whom. We expect the 10 Year Health Plan to set out more detail on the wider system architecture and clarify the role and accountabilities of trusts, systems, and the centre of the NHS.

We are sharing this blueprint with you today without the corresponding picture of what the future of neighbourhood health will look like or the role of the centre or regional teams.

We are also sharing this now without the benefit of the wide engagement with staff and stakeholders that will be required to get the detail and implementation right. Given the pace at which this work has been developed over recent weeks, our initial focus has been system-led design. We are now sharing it more widely for discussion and refinement and will be setting up engagement discussions over the coming weeks.

This blueprint document marks the first step in a joint programme of work to reshape the focus, role and functions of ICBs, with a view to laying the foundations for delivery of the 10 Year Health Plan. It is clear that moving forwards, ICBs have a critical role to play as strategic commissioners working to improve population health, reduce inequalities and improve access to more consistently high-quality care and we look forward to shaping the next steps on this together.

1. Context

In July 2022, Integrated Care Boards (ICB) were established with the statutory functions of planning and arranging health services for their population, holding responsibility for the performance and oversight of NHS services within their footprint. Alongside these system leadership and commissioning roles, they were also set up with a range of delivery functions, including emergency planning, safeguarding and NHS Continuing Healthcare assessment and provision.

As the Darzi review noted¹, since 2022, there have been differing interpretations of the role of ICBs, with some leaning towards tackling the social determinants of health, some focused on working at a local level to encourage services to work more effectively together, and some focused on supporting their providers to improve (in particular) financial and operational performance. The wider context, including performance measures focused on hospitals and the requirement for ICBs to ensure their Integrated Care System (ICS) delivers financial balance, mean that ICBs have found it hard to use their powers to commission services in line with the four ICS objectives. This has largely resulted in the status quo with increasing resources directed to acute providers, when the four objectives should have instead led to the opposite outcome.

As the Darzi review concludes, the roles and responsibilities of ICBs need to be clarified to provide more consistency and better enable the strategic objectives of redistributing resource out of hospital and integrating care. Crucial to this is a rebuilding of strategic commissioning capabilities, requiring “*as strong a focus on strategy as much as performance*” and a parallel investment in the skills required to “*commission care wisely as much as to provide it well*”.

The 10 Year Health Plan will reinforce the criticality of this role and the Secretary of State is clear about his desire – and the need – to deliver the three shifts. The NHS needs to deliver better value for its customers – the population of England. This means increasingly focusing on prevention and reducing inequalities, delivering more services in a community/ neighbourhood based setting – and ensuring all services are delivered as efficiently and effectively as possible, in particular through the use of technology.

Across the NHS, these three strategic shifts form the foundation of the Model ICB’s approach to transformation and redesign:

- **treatment to prevention:** A stronger emphasis on preventative health and wellbeing, addressing the causes of ill health before they require costly medical intervention and

¹ <https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england>

reducing inequalities in health. This involves proactive community and public health initiatives, working closely with local authorities, to keep people healthy.

- **hospital to community:** Moving care closer to home by building more joined-up, person-centred care in local neighbourhoods, reducing reliance on acute care.
- **analogue to digital:** Harnessing technology and data to transform care delivery and decision-making. From digital health services for patients, to advanced analytics (population health management, predictive modelling) for planners, the focus is on smarter, more efficient, and more personalised care.

These shifts set the direction for how ICBs need to operate going forward. The NHS needs strong commissioners who can better understand the health and care needs of their local populations, who can work with users and wider communities to develop strategies to improve health and tackle inequalities and who can contract with providers to ensure consistently high-quality and efficient care, in line with best practice.

This document, developed by a working group consisting of ICB leaders from across the country, sets out a blueprint for how ICBs can operate within a changing NHS landscape. It covers the following areas:

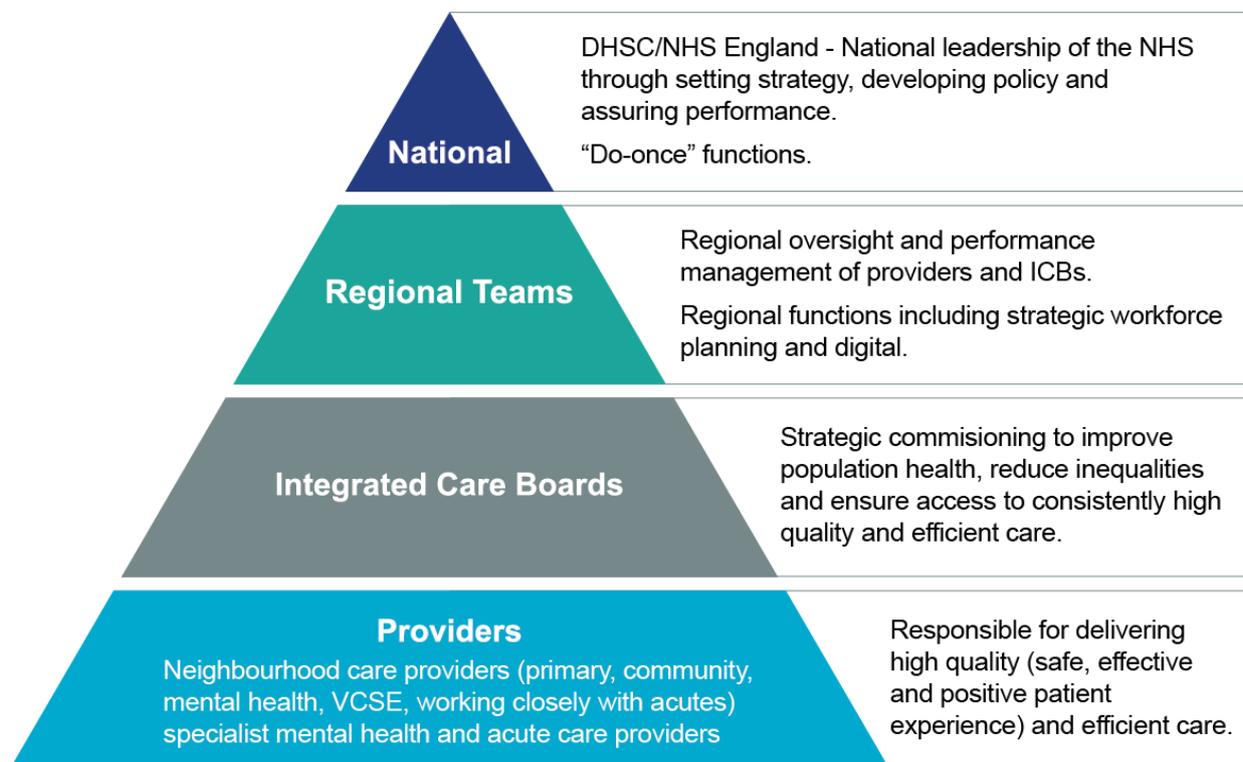
- **purpose** – why ICBs exist
- **core functions** – what they do
- **enablers and capabilities** – what needs to be in place to ensure success
- **managing transition** – supporting ICBs to manage this transition locally and the support and guidance that will be available.

2. Purpose and role: why ICBs exist

ICBs exist to improve their population's health and ensure access to consistently high-quality services. They hold the accountability for ensuring the best use of their population's health budget to improve health and healthcare, both now and in the future.

ICBs provide system leadership for population health, setting evidence based and long-term population health strategy and working as healthcare payers to deliver this, maximising the value that can be created from the available resources. This involves investing in, purchasing and evaluating the range of services and pathways required to ensure access to high quality care, and in order to improve outcomes and reduce inequalities within their footprint. ICBs not only commission services but also align funding and resources strategically with long-term population health outcomes and manage clinical and financial risks.

The refreshed role of ICBs has been developed through a set of assumptions about a refreshed system landscape, along the lines set out below:



3. Core functions: What ICBs do

To deliver their purpose, ICBs focus on the following core functions:



The following table summarises the activities that make up these core functions.

Model ICB core functions and activities

Activity	Detail
1. Understanding local context: assessing population needs now and in the future, identifying underserved communities and assessing quality, performance and productivity of existing provision	
Population data and intelligence	<ul style="list-style-type: none"> • Using data and intelligence (including user feedback, partner insight, outcomes data, public health insight) to develop a deep and dynamic understanding of their local population and their needs and how these are likely to change over time • Leveraging real-time data and predictive modelling to identify risk, understand variation, and direct resources where they will have the greatest impact (allocative efficiency) • Segmenting their population and stratifying health risks • Dis-aggregating population health data to surface inequalities, generate actionable insights, inform service design and deployment and scrutinise progress towards equity
Forecasting and modelling	<ul style="list-style-type: none"> • Developing long-term population health plans using epidemiological, actuarial, and economic analysis • Forecasting and scenario modelling demand and service pressures • Understanding current and future costs to ensure clinical and financial sustainability • Convening people, communities and partners to challenge, critique and inform population health plans, demand modelling and cost forecasts
Reviewing provision	<ul style="list-style-type: none"> • Reviewing current provision using data and input from stakeholders, people and communities • Building a deep understanding of operational performance, quality of care (safety, effectiveness, user experience) and productivity/unit cost across all providers
2. Developing long term population health strategy: Long-term population health planning and strategy and care pathway redesign to maximise value based on evidence	
Developing strategy with options for testing and engagement	<ul style="list-style-type: none"> • Drawing on a variety of inputs (analysis of population health needs, evidence base on what works, national and international examples, user priorities, innovation and horizon scanning, bottom-up costing, principles of healthcare value, impact/feasibility analysis) to develop strategic options for testing and engagement with partners, people and communities • Developing and agreeing best practice care pathways with partners, people and communities, using national guidance and working closely with local clinical leaders to inform this

	<ul style="list-style-type: none"> Aligning funding with need and impact using locally adapted actuarial models and bottom-up costing (“should cost” principles) Ensuring efficiency and equity using value-based approaches to prioritisation, underpinned by public health principles
Setting strategy	<ul style="list-style-type: none"> Setting overall system strategy to inform allocation of resources to maximise improved health and access to high quality care (safety, effectiveness, user experience), shifting focus from institutions to population outcomes, and targeting health inequalities by improving equity of access, experience and outcomes Determining where change is required, the priority outcomes for improvement and population metrics to track Co-producing strategy with communities, reflecting unmet needs and targeting inequalities Designing new care models and investment programmes and co-ordinating major transformation programmes Collaborating with local authorities, place-based partnerships, provider collaboratives, academia, think tanks, and analytics partners to develop and refine strategy
3. Delivering the strategy through payer functions and resource allocation: oversight and assurance of what is purchased and whether it delivers outcomes required	
Strategic purchasing	<ul style="list-style-type: none"> Aligning funding to needs using data-driven models Defining outcome-linked service specifications Setting strategic priorities for quality assurance and oversight, developing policies and frameworks for quality improvement Prioritising interventions to address health inequalities
Market shaping and management	<ul style="list-style-type: none"> Understanding the different costs and outcomes of a range of providers Building robust “should cost” and “should deliver” models to test against Introducing and encouraging new providers where gaps exist in the market, for example, frailty models Working with providers to understand factors necessary for sustainability, for example, the link between elective orthopaedics and trauma Exploring a range of payment mechanisms
Contracting	<ul style="list-style-type: none"> Negotiating and managing outcome-based contracts Monitoring provider performance and benchmarking services with continuous review of impact, access and quality Using performance frameworks, invoice validation Establishing procurement governance, value-for-money checks

Payment mechanisms	<ul style="list-style-type: none"> • Designing incentives (blended payments, gainshare, shared savings) to improve equity, efficiency and productivity • Implementing risk mitigation strategies (for example, collaborative risk-pools) • Using financial stewardship tools (cost-effectiveness thresholds, return on investment) • Deploying payment models to improve equity (for example, blended payments linked to reducing inequalities)
4. Evaluating impact: day-to-day oversight of healthcare utilisation, user feedback and evaluation to ensure optimal, value-based resource use and improved outcomes	
Utilisation management	<ul style="list-style-type: none"> • Day-to-day oversight of service usage using real-time dashboards (admissions, urgent and emergency care attendances, prescribing, coding etc.) • Identifying unwarranted care variations utilising benchmarking tools and clinical audits and unwarranted over treatment, for example cataracts • Convening clinical reviews and managing complex cases • Optimising care pathways with providers
Evaluating outcomes	<ul style="list-style-type: none"> • Evaluating the outcomes from commissioned services • Rigorous monitoring of priority metrics, identifying unwarranted variation and clear feedback loops to inform commissioning adjustments and understand the return on investment • Establishing feedback loops for adaptive planning • Embedding feedback from people and communities, staff and partners into evaluation approaches
User feedback, co-design and engagement	<ul style="list-style-type: none"> • Evaluation, co-design and deliberative dialogue with people and communities, using design thinking methodologies • Ensuring user feedback mechanisms are embedded in how resource is allocated and evaluated
Governance and Core Statutory Functions: Ensures the ICB is compliant, accountable, and safe	
Ensuring the ICB is compliant, accountable and safe	<ul style="list-style-type: none"> • Establishing robust governance structures and processes to ensure legal compliance, transparency and public accountability • Fulfilling statutory duties (for example, equality, public involvement) and monitoring of equity outcomes alongside access, quality, and efficiency • Implementing strong clinical and information governance and effective financial and risk management systems • Maintaining business continuity and emergency planning • Overseeing delegated functions with proportionate assurance

ICB functional changes

To support the development of the future state, ICBs should consider the following assumptions about some of the functional changes that could happen. We are sharing this to provide an indication of the future state, however the detail and implementation will depend on multiple factors, including engagement and refinement with partners, the parallel development of provider and regional models, readiness to transfer and receive across different parts of the system and, in some cases, legislative change.

ICBs will need to work closely with their staff to ensure they are supported, to retain talent and to safely manage delivery across the wider system and public sector, including when functions move to different parts of the landscape.

Given the implications of these functional changes on different parts of the system, next steps will need to be developed by working closely with partners nationally and within local systems over the coming months. In light of this, no specific timeframes are provided at this stage.

ICB functional changes		
Change to manage	Functions in scope	Guiding notes
Grow: functions for ICBs to grow / invest in over time to deliver against the purpose and objectives	Population health management – data and analytics, predictive modelling, risk stratification, understanding inequalities	<ul style="list-style-type: none"> • Essential for core role and activities • Can be delivered within existing legislation • Will require investment in new capabilities over time
	Epidemiological capability to understand the causes, management and prevention of illness	
	Strategy and strategic planning including care pathway redesign	
	Health inequalities and inclusion expertise – capacity and capability to routinely disaggregate population and performance data to surface health inequalities, generate actionable insights, drive	

	evidence informed interventions and build intelligence to guide future commissioning and resource allocation decisions	
	Commissioning neighbourhood health	
	Commissioning of clinical risk management and intervention programmes (working with neighbourhood health teams to ensure proactive case finding)	
	Commissioning end-to-end pathways (including those delegated by NHS E: specialised services; primary medical, pharmacy, ophthalmic and dental services (POD); general practice, and further services that will be delegated by NHS England to ICBs over time) <i>Vaccinations and screening will be delegated by NHS England to ICBs in April 2026</i> <i>All remaining NHS England direct commissioning functions will be reviewed during 2025/26</i>	
	Core payer functions – strategic purchasing, contracting, payment mechanisms, resource allocation, market shaping and management, utilisation management	
	Evaluation methodologies and evidence synthesis using qualitative and quantitative data, feedback and insights	

	User involvement, user led design, deliberative dialogue methodologies	
	Strategic partnerships to improve population health (public health, local partners, VCSE, academia, innovation)	
Selectively retain and adapt: functions for ICBs to retain and adapt including by delivering at scale	Quality management – understanding drivers of improved health, range of health outcome measures, elements of high-quality care (safety, effectiveness, user experience); child death reviews	<ul style="list-style-type: none"> • Embed in commissioning cycle, monitoring of contracts • Avoid duplication with providers, regions and CQC • Use automated data sources and single version of the truth
	Board governance	<ul style="list-style-type: none"> • Look to streamline Boards to deliver core role as set out • Headcount should be reduced at Board level with the right roles and profiles to deliver core Model ICB functions
	Clinical governance	<ul style="list-style-type: none"> • Strengthen focus on embedding management of population clinical risk, best practice care pathways in commissioning approach
	Corporate governance (including data protection, information governance, legal services)	<ul style="list-style-type: none"> • Maintain good governance practice; look to deliver some functions at scale across ICBs
	Core organisational operations (HR, communications, internal finance, internal audit, procurement, complaints, PALs)	<ul style="list-style-type: none"> • Look to streamline and deliver some functions at scale
	Existing commissioning functions, including clinical policy and effectiveness – local funding decisions (individual funding	<ul style="list-style-type: none"> • Will be built into new commissioning/payer functions operating at ICB and pan-ICB level

	requests; clinical policy implementation)	
Review for transfer: functions and activities for ICBs to transfer over time , enabled by flexibilities under the 2022 Act for ICBs to transfer their statutory duties	Oversight of provider performance under the NHS performance assessment framework (finance, quality, operational performance)	<ul style="list-style-type: none"> • Performance management, regulatory oversight and management of failure to transfer to regions through the NHS Performance and Assessment Framework • Market management and contract management functions to be retained and grown in ICBs
	Emergency Preparedness, Resilience and Response (EPRR) and system coordination centre	<ul style="list-style-type: none"> • Transfer to regions over time
	High level strategic workforce planning, development, education and training	<ul style="list-style-type: none"> • Transfer to regions or national over time, retain limited strategic commissioning overview as part of strategy function
	Local workforce development and training including recruitment and retention	<ul style="list-style-type: none"> • Transfer to providers over time
	Research development and innovation	<ul style="list-style-type: none"> • Transfer to regions over time, with ICBs retaining and building strategic partnerships to support population health strategy
	Green plan and sustainability	<ul style="list-style-type: none"> • Transfer to providers over time
	Digital and technology leadership and transformation	<ul style="list-style-type: none"> • Transfer digital leadership to providers over time enabled by a national data and digital infrastructure
	Data collection, management and processing	<ul style="list-style-type: none"> • Transfer to national over time
	Infection prevention and control	<ul style="list-style-type: none"> • Test and explore options to streamline and transfer some activities out of ICBs

	Safeguarding	<ul style="list-style-type: none"> • Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	SEND	<ul style="list-style-type: none"> • Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	Development of neighbourhood and place-based partnerships	<ul style="list-style-type: none"> • Transfer to neighbourhood health providers over time
	Primary care operations and transformation (including primary care, medicines management, estates and workforce support)	<ul style="list-style-type: none"> • Transfer to neighbourhood health providers over time
	Medicines optimisation	<ul style="list-style-type: none"> • Transfer delivery to providers over time, retain strategic commissioning overview as part of strategy function
	Pathway and service development programmes	<ul style="list-style-type: none"> • Transfer to providers, retain strategic commissioning overview as part of strategy function
	NHS Continuing Healthcare	<ul style="list-style-type: none"> • Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	Estates and infrastructure strategy	<ul style="list-style-type: none"> • Transfer to providers over time, retain limited strategic commissioning overview as part of strategy function
	General Practice IT	<ul style="list-style-type: none"> • Explore options to transfer out of ICBs ensuring consistent offer

4. Enablers and capabilities: what ICBs need to ensure success

For an ICB to effectively perform the core functions set out in section 3, several key enablers need to be in place. A high-level summary of these is set out below:

- **Healthcare data and analytics** – to enable ICB decisions to be guided by population health data and insights, ICBs will need to develop strong population health management approaches underpinned by robust data capability. This will need to include developing the capabilities to segment the population and stratify risk and build a person-level, longitudinal, linked dataset integrating local and national data sources alongside public and patient feedback. There will need to be appropriate data-sharing and governance agreements to track individuals' journeys across health and care (to understand needs and outcomes holistically); and deploy predictive modelling to foresee future demand, cost and impact of interventions. ICBs will need to cultivate teams with the ability to analyse and interpret complex data (health economists and data-scientists) and deploy data-driven techniques (such as modelling the return on investment for preventative interventions). Data can be integrated reliably between services to provide real-time, accurate data enabling better decision-making and interoperability – the NHS Federated Data Platform (FDP) will be crucial to enable this work, and should be used as the default tool by ICBs.
- **Strategy** – ICBs will need to develop effective strategy capability, comprised of individuals with good problem solving and analytical skills. They will need to foster a greater understanding of value-based healthcare alongside the ability to synthesise a range of information (qualitative and quantitative) and develop actionable insights to support prioritisation. ICBs will need strategic leaders who can diplomatically and collaboratively work with a range of partners including by facilitating multi-agency forums and collaborative decision-making. They will also need the ability to navigate and synthesise complexity so that people and communities, staff and partners can understand the full picture, and be able to draw people together around the shared goal of improving population health.
- **Intelligent healthcare payer** – for ICBs to develop into sophisticated and intelligent healthcare payers, they will need to invest in their understanding of costs ('should cost' analysis) and wider finance functions, developing capabilities in strategic purchasing, contracting, design and oversight of payment mechanisms, utilisation management and resource allocation. This will need to include commercial skills for innovative contracting and managing new provider relationships. ICB staff will need to learn how to proactively manage and develop the provider market, using procurement and contracting levers to incentivise quality improvement and innovation. This should involve techniques that ensure effective use of public resources so that investment decisions are guided by

relative value, not just demand or precedent. This calls for deliberate use of tools such as programme budgeting and decommissioning frameworks to support allocative efficiency.

- **User involvement and co-design** – for services to truly meet communities’ needs, people must be involved from the very start of planning through to implementation and review. Each ICB should have a systematic approach to co-production – meaningfully involving patients, service users, carers, and community groups in designing solutions. This goes beyond formal consultation and means working with people as partners. ICBs will need to ensure that focused effort and resources are deployed to reach seldom heard and underserved people and communities, working with trusted community partners to achieve this. Ultimately, this enabler is about shifting the relationship with the public from passive recipient to active shaper of health and care, with a particular focus on underserved communities.
- **Clinical leadership and governance** – ICBs will need effective clinical leadership embedded in how they work, ensuring they have a solid understanding of population clinical risk and of the best practice care pathways required to meet population needs and improve outcomes. Clinical governance and oversight will be crucial in ensuring that the decisions that ICBs make are robust, particularly regarding the prioritisation of resources. Contract management of commissioned services will need to include effective quality assurance processes.
- **System leadership for population health** – effective system leadership will be essential to driving improvements in population health. ICB leaders and staff need to be adept at system thinking, analytics, and collaboration. They will need to work diplomatically and be comfortable driving change and influencing without direct authority. ICBs should develop and foster strategic partnerships across their footprints with a range of partners (including academia, VCSE, innovation), alongside working together with providers and local government as they develop and implement their strategies.
- **Partnership working with local government** – recognising the critical and statutory role of local authorities in ICSs and as partner members of ICBs, engagement and co-design with local government will be critical to the next phase of this work. Linked to this, is the need for ICBs to continue to foster strong relationships with the places within their footprint, building a shared understanding of their population and working together to support improved outcomes, tackle inequalities and develop neighbourhood health. We will be working jointly with the Local Government Association to take this development work forwards.
- **Supporting ICB competency and capability development – national support offer and maturity assessment** – it is proposed that a national programme of work, including

a new commissioning framework, is developed to ensure ICBs have the necessary capabilities and competencies to discharge their functions effectively. This should be developed by learning from successful international models and World Class Commissioning and form the basis of future assessments of ICB maturity.

5. Managing the transition

The ask on ICBs is significant this year as they work to maintain effective oversight of the delivery of 2025/26 plans, build the foundation for neighbourhood health and manage the local changes involved with ICB redesign, including supporting their staff through engagement and consultation.

To support with this, the following sections set out some high-level principles around:

- delivering ICB cost reductions plans and realising the savings
- managing the impact on staff
- designing leadership structures of ICBs
- managing risk during transition through safe governance
- expectations for safe transition of transferred functions

Delivering ICB cost reductions plans and realising the savings

ICBs will need to use this guidance to create bottom-up plans which are affordable within the revised running cost envelope of £18.76 per head of population. More details on this are set out below:

- the calculations to derive the £18.76 operating cost envelope include all ICB running costs and programme pay (only excluding POD and specialised commissioning delegation)
- the reduction in ICB costs to meet this target must be delivered by the end of Q3 2025/26 and recurrently into 2026/27
- ICBs are encouraged to expedite these changes as any in-year savings can be used on a non-recurrent basis to address in-year transition pressures or risks to delivery in wider system operational plans and potentially sooner to mitigate and de-risk financial plans
- there will be flexibility at an ICB-level, as some inter-ICB variation may be warranted and will need to be managed within a region to account for hosted services, however we expect delivery of the target at an aggregate regional level
- generating savings cannot be a cost shift to a provider unless overall there is the saving, for example, a provider takes on an ICB operated service and therefore requires circa 50% less cost in line with the £18.76 running cost envelope

We recognise that not all functional changes to reach the Model ICB can be done this year as some changes will require legislation and any transfer arrangements will need to be

carefully managed to ensure safe transition. Recognising this, we anticipate that most savings will come from streamlining approaches, identifying efficiency opportunities – through benchmarking, AI and other technological opportunities and from at scale opportunities afforded through greater collaboration, clustering and where appropriate, eventual merger of ICBs. Principles to apply to footprints, clustering and mergers will be communicated and coordinated by regional teams.

NHS England is providing a planning template to facilitate the May 2025 plan returns. This will be issued in the week commencing 6 May 2025. Plans should be submitted to your regional lead by 5pm on **30 May 2025**. Plans will set out how each ICB intends to achieve the £18.76 operating cost envelope and will then go through a national moderation process (involving a confirm and challenge process) to support consistency of approach and sharing of opportunities. These plans should be informed at a high level by the vision set out in this blueprint.

Support for managing the impact on staff

A national support offer will be available to ensure fair and supportive treatment of staff affected by the transition. This includes advice on voluntary redundancy and Mutually Agreed Resignation Schemes (MARS), along with guidance on redeployment and retention where appropriate. Funding mechanisms to support these options will be clarified centrally ensuring local systems can manage workforce changes consistently. Emphasis will be placed on transparent, compassionate communication and engagement to retain talent and maintain morale through the change process. We will work in partnership with trade union colleagues to implement the change for staff.

Advice on leadership structures of ICBs

ICBs are expected to maintain clear, accountable leadership with effective governance during the transition and beyond. ICBs should look to streamline Boards and reduce headcount at Board level to deliver core purpose and role as described. Leadership structures and executive portfolios should also reflect the functions as set out above, including skills in population health data and insights, strategic commissioning (including strategy, partnerships and user involvement), finance and contracting and clinical leadership and governance. At Board level, a strong non-executive presence is encouraged to support both oversight and the delivery of transition priorities.

Managing risk during transition through safe governance

To ensure a safe and coherent transition, each ICB should establish a dedicated Transition Committee, including both executive and non-executive members. These committees will take responsibility for managing local risks, tracking progress, and overseeing the development of organisational design and implementation of change processes.

To support this work, a central NHS England programme team — under the leadership of an Executive SRO — will be set up to provide coordination, support and a check and challenge process on ICB plans. This will seek to ensure appropriate support guidance is developed to facilitate the transition, share best practices, and facilitate consistency across systems to deliver the vision set out here. This central support will also help ICBs navigate legal, operational, and workforce challenges while ensuring focus remains on delivery of statutory duties throughout the transition.

Expectations for safe transition of transferred functions

Safe transition of functions is critical to the success of the new Model ICB design and the future system landscape. To manage this transition effectively, an assessment of readiness is necessary for both the sender and the receiver. Implementing a gateway process will help verify readiness before transferring staff and functions underpinned by clear governance frameworks, outcome metrics, financial risk arrangements, and escalation protocols to ensure safe and effective delivery.

NHS England is currently developing the operating model for the Model Region. We will continue to work with ICBs as we develop the regional approach to ensure alignment with the Model ICB design and implementation. We have been clear that performance management of providers against the NHS Performance and Assessment Framework (NPAF) will transfer to Regions under the new design. It will be important to be clear on responsibilities as these functions transfer. Once transferred ICBs will oversee providers through their contracting arrangements but will not be responsible for leading the regulatory oversight of providers against the NPAF.

Frequently asked questions

FAQs covering all aspects of transition is being developed to support ICBs as they manage these elements locally.

Please direct any questions to england.Model-ICB@nhs.net and we will use these to inform future sets of FAQs.

Terms of Reference for South East England ICBs –

CEO Joint Committee

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Introduction

1. The Integrated Care Boards (ICBs) across the South East of England have come together to form the Collaborative South East ICBs Chief Executive Officers Joint Committee ('**Joint Committee**').
2. The NHS ICB partner members are:
 - (a) NHS Frimley ICB ('**Frimley ICB**')
 - (b) NHS Buckinghamshire, Oxfordshire and Berkshire ICB ('**BOB ICB**')
 - (c) NHS Hampshire and the Isle of Wight ICB ('**HIoW ICB**')
 - (d) NHS Kent and Medway ICB ('**Kent & Medway ICB**')
 - (e) NHS Surrey Heartlands ICB ('**Surrey Heartlands ICB**')
 - (f) NHS Sussex ICB ('**Sussex ICB**')
3. For the purpose of these terms of reference, the NHS ICBs shall be known as the '**ICB Partners**'.
4. The Joint Committee, whose governance arrangements are described in these terms of reference, is the collective governance vehicle for joint decision-making by the ICB Partners.

Purpose

5. The ICB Partners wish to collaborate on a number of priority areas that can be best done at scale together for the population of the nine million people which they serve. They have agreed a programme of work that aims to commission and support the local delivery of five key collaborative priorities. These are:
 - (a) Using a common approach for the Federated Data Platform (FDP) and to roll this out across the south east.
 - (b) Reviewing and assessing commissioning of delegated services, including specialist commissioning, pharmacy, optometry and dentistry services to identify opportunities to collaboratively commission improved, high quality, modern, strategic clinical services. This will include forward planning for further areas of delegated commissioning in the future.
 - (c) Culture and leadership: Developing a system approach for the south east ICBs; sharing risk and benefits, where this is beneficial to south east populations, as a whole. Creating the best possible culture and leadership for the south east.
 - (d) Financial sustainability: Recognising financial challenges across the systems and interdependencies, to work together where possible and where it makes sense to support ICBs and systems to achieving greater financial sustainability and productivity.

- (e) Strategic and collaborative commissioning at scale: Focussing on:
 - i. the urgent and emergency care pathway to enable a collective approach to ambulance services
 - ii. a review of mental health services to improve care in a more consistent way for people with a mental health condition.
- 6. The ICB Partners already collaborate on a number of areas, including workforce, prescribing and medicine management, continuing healthcare and some corporate services such as procurement and diagnostics. Over time, there may be more areas that can be better achieved with ICBs working together at scale.
- 7. For clarity, the list of delegated functions within scope of this Joint Committee are set out in **Appendix A**
- 8. The ICB Partners may establish sub-committees and working groups of the Joint Committee, with such terms of reference as may be agreed between them. Any such sub-committees or working groups that are in place at the commencement of this Agreement may be documented in the Local Terms for ICB Partners (**Appendix B**).

The Terms of Reference

- 9. These Terms of Reference provide the governance framework to support effective collaboration between the ICB Partners acting through the Joint Committee.
- 10. The Terms of Reference set out the role, responsibilities, membership, decision-making powers, and reporting arrangements of the Joint Committee. They should be read alongside the respective Collaboration Agreements between the ICB Partners ('the Collaboration Agreements') and any other authority delegating functions to them, such as NHS England through the Specialised Commissioning Delegation Agreement ('the Delegation Agreement').
- 11. It is acknowledged that, amongst other programmes as detailed in paragraph 5, these joint working arrangements enable ICB Partners to work together as a collective in relation to collaborative commissioning and the commissioning of Specialised Services, to better align and transform pathways of care around the needs of local populations in South East England.
- 12. The Joint Committee will operate as the decision-making forum for exercising the agreed delegated joint functions in accordance with the associated Collaboration Agreements and the Delegation Agreement functions.

Statutory framework

- 13. Section 65Z5 of the National Health Service Act 2006 (as amended) ('the NHS Act') permits NHS organisations to delegate their functions to other statutory bodies. It also

permits combinations of NHS organisations to jointly exercise their functions and pool funds in a joint working arrangement.

14. In accordance with sections 65Z5 and 65Z6 of the NHS Act, ICBs can establish and maintain joint working arrangements, overseen by a Joint Committee, to jointly exercise their commissioning functions.
15. The CEO Joint Committee is established pursuant to section 65Z6 of the NHS Act and apart from the functions set out in the Collaboration and Delegation Agreements, as reflected in these terms of reference, the Joint Committee does not affect the statutory responsibilities and accountabilities of the ICB Partners.

Role of the Joint Committee

16. The role of the Joint Committee shall be to carry out the strategic decision-making, leadership and oversight relating to the commissioning of a range of services as detailed in Appendix A and any associated Collaboration and Delegation Agreements. The Joint Committee will share good practice relating to the needs of the partners and their populations wherever collaborative working will bring positive impact. The Joint Committee will safely, effectively, efficiently and economically discharge the Delegated Functions and deliver the relevant services through the following key responsibilities:
 - a) Determining the appropriate structure of the Joint Committee for approval by each ICB Partner;
 - b) Making joint decisions in relation to the planning and commissioning of the Delegated Functions and relevant services, and any associated commissioning or statutory responsibilities, for the population, for example, through undertaking population needs assessments, in association with other public authorities if deemed appropriate;
 - c) Have due regard to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources in all decision-making;
 - d) Monitoring and delivering the population-based financial allocation and financial plans for services commissioned by the ICB Partners, including agreeing the annual contribution made by each ICB Partner;
 - e) Oversight and assurance of the delegated functions and relevant services in relation to quality, operational and financial performance, including co-ordinating risk and issue management and escalation, and developing the approach to intervention with service providers where there are quality or contractual issues;
 - f) Identifying and setting strategic priorities and undertaking ongoing assessment and review of delegated functions and relevant services within the remit of the Joint Committee, including tackling unequal outcomes and access;

- g) Supporting the development of partnership and integration arrangements with other health and care bodies that facilitate population health management and, providing a forum that enables collaboration to integrate service pathways, improve population health and services, and reduce health inequalities. This includes establishing links and working effectively with health and care partners including Provider Collaboratives and other alliances, other ICBs, joint committees and NHS England where there are cross-border patient flows to providers;
- h) Ensuring the Joint Committee has effective engagement with stakeholders, including local authorities, patients and the public, and involving them in decision-making;
- i) Ensuring the Joint Committee has appropriate clinical advice and leadership, including through relevant Clinical Reference Groups and Clinical Networks;
- j) Ensuring that, prior to a decision being made by the Joint Committee in relation to the delegated functions and relevant services, appropriate consideration by relevant clinicians and other relevant disciplines has been undertaken;
- k) Ensuring that prior to a decision being made by the Joint Committee in relation to the delegated functions and relevant services, appropriate consideration is given to each ICB Partner's Scheme of Reservation and Delegation ('SoRD'), and such Joint Committee SoRD as may be established
- l) Commencing longer-term planning of the delegated functions and relevant services, including the opportunities for transformation and integration of the services and delegated functions;
- m) Discussing any matter which any member of the Joint Committee considers to be of such importance that it should be brought to the attention of the Joint Committee;
- n) Review and renew the operation of these terms of reference, as required, subject to the terms of any existing contractual commitments; and
- o) Otherwise ensuring that the roles and responsibilities set out in the associated Collaboration and Delegation Agreements between the ICB Partners are discharged.

17. The list of delegated functions within scope of this Joint Committee are set out in Appendix A. Where appropriate these delegated functions will also have related Collaboration and Delegation Agreements which must be adhered to alongside these Terms of Reference. Where there is any difference between the Agreements the following shall take precedence in priority order:

- a) The Delegation Agreement
- b) The Collaboration Agreement
- c) These Terms of Reference

18. Any ICB Functions delegated by the ICB Partners shall be appropriately referenced in the ICB Partners Scheme of Reservation and Delegation.

Accountability and reporting

19. The ICB Partners of the Joint Committee are accountable to their respective Boards for the exercise of the Delegated Functions, and NHS England for the exercise of the Delegated Functions related to Specialised Commissioning.

20. It is the responsibility of each ICB Partner to determine the route by which it receives assurance from, and contributes to, the decision making of the Joint Committee. It is the responsibility of each Authorised Officer of the Committee to operate within the governance structure of their organisation in order to provide such assurance using the route agreed by their organisation.

21. Any sub-committee of the Joint Committee will be Chaired by a voting member of the Joint Committee who will formally report on the work of the sub-committee at each Joint Committee meeting.

22. The Chair of any Working Group established by the Joint Committee or a sub-committee will provide a formal report to the Chair of the Joint Committee or relevant sub-committee within 7 days of each Working Group meeting.

23. The Joint Committee or relevant sub-committee will provide a report on how it has exercised the Specialised Commissioning Delegated Functions set out in the Delegation Agreement to such officer as NHS England authorises to receive such reports.

Proposals for sub-committees and work programmes

24. The ICB Partners may, from time to time, establish sub-committees or working groups of the Joint Committee to discharge its functions, with such terms of reference as may be agreed between them. Any such sub-committees or working groups that are in place at the commencement of the relevant ICB Collaboration Arrangement may be documented in the relevant schedules to that agreement. Sub committees and working groups will be described in the governance arrangements in the respective Collaboration Agreement.

25. All sub-committees will have their terms of reference and membership approved by the Joint Committee and will need to operate in accordance with any requirements specified by the Joint Committee.

26. Any Working Group established by a sub-committee will have its terms of reference and membership approved by the relevant sub-committee and will need to operate in accordance with any requirements specified by that subcommittee.

Membership

27. The Chief Executive of each ICB Partner shall be a member of the Joint Committee. In their absence, a Chief Executive may appoint a named substitute to attend. The named

substitute shall have the same decision-making authority as their Chief Executive for the purposes of the Joint Committee.

28. Where a Chief Executive has a conflict of interest on a particular matter, the relevant ICB Partner may nominate a named substitute to attend the meeting of the Joint Committee as a member for that item, subject to them not being conflicted.
29. Each of the ICB Partners must ensure that its Chief Executive, or deputy or named substitute is of a suitable level of seniority and duly authorised to act on its behalf and to agree to be bound by the final position or decision taken at any meeting of the Joint Committee.
30. NHS England will not be a member of the Joint Committee but will have a standing invitation to attend each meeting of the Joint Committee.

Membership of Sub-Committees and Working Groups

31. The Joint Committee will determine the membership of each sub-committee and working group it establishes, and members do not need to be voting members of the Joint Committee, but each sub-committee must be chaired by a voting member of the Joint Committee.
32. Each sub-committee which establishes a working group will appoint one of its voting members to chair such a working group, but the rest of the membership does not have to come from the sub-committee.

Representative and Attendees

33. The ICB Partners may identify individuals from their own organisations or other organisations to observe proceedings, contribute to the Joint Committee's deliberations and provide advice to the Joint Committee, as required. These individuals will attend the Joint Committee in an advisory capacity only.
34. Such attendees will need to be agreed with the Chair of the Joint Committee in advance of the meeting.

Chair

35. At the first meeting of the Joint Committee, the Members shall select a Chair or joint Chairs from among the membership.
36. The Chair(s) shall hold office for a period of one year and be eligible for re-appointment for further terms. At the first scheduled Joint Committee meeting after the expiry of the Chair's term of office, the Members will select a Chair or joint Chairs who will assume office at that meeting and for the ensuing term
37. If the Chair(s) is/are not in attendance at a meeting, the remaining Members will select a Member to take the chair for that meeting.

Levels of Delegated Authority

38. The level of delegated authority the Joint Committee shall have for decision making, shall be the individual level of delegated authority for each of the Joint Committee Members in accordance with their respective Scheme of Reservation and Delegation or Standing Financial Instructions. This should ideally be the same level of authority for each Member. Where it is not, Members of the Joint Committee should try to collectively agree a suitable level of delegated authority to recommend to their respective ICB Partner organisations.
39. The level of delegated authority to the Joint Committee Members for each of the delegated functions does not have to be the same: it may differ in accordance with their respective ICB Scheme of Reservation and Delegation or Standing Financial Instructions.

Meeting arrangements

40. The Joint Committee shall plan to meet six times per year, as a minimum.
41. At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Joint Committee shall prepare a schedule of meetings for the forthcoming year ("the Schedule").
42. The Chair(s) (or in the absence of a Chair, the ICB Partners themselves) shall see that the Schedule is notified to the members.
43. The ICB Partners (individually or collectively) may call for an extraordinary meeting of the Joint Committee outside of the Schedule as they see fit, by giving notice of their request to the Chair(s). The Chair(s) may, following consultation with the Partners, confirm the date on which the extraordinary meeting is to be held.

Quorum

44. A Joint Committee meeting is quorate if the Member appointed by each of the ICB Partners is present.
45. An ICB Partner that is unable to attend a scheduled meeting of the Joint Committee must provide at least seven days' notice in writing to the Chair(s) to allow alternative arrangements to be considered.
46. Where an ICB Partner is unable to comply with paragraph 45 and does not attend the meeting of the Joint Committee, the meeting shall proceed on the basis that it is quorate, but insofar that any binding joint decision will need to be ratified at the next meeting of the Joint Committee. The Chair will make every effort to confirm the decision with the absent ICB partner in advance of this, but regardless, the decision must be ratified at the next meeting. Failure to ratify the decision will mean it is not binding..
47. Further to paragraph 46, any joint decision binding on all Partners must relate to an issue already notified to the ICB Partners as part of the meeting agenda or papers for the

meeting. Any decision on an issue not previously notified to all of the ICB Partners will not be binding on the absent ICB Partner.

Secretariat functions

48. The ICB Partners shall provide sufficient resources, administration and secretarial support to ensure the proper organisation and functioning of the Joint Committee.

Publication of notices, minutes and papers

49. The Chair(s) shall ensure that notices of meetings of the Joint Committee, together with an agenda listing the business to be conducted and supporting documentation, are issued to the ICB Partners seven days (or, in the case of an extraordinary meeting, three working days) prior to the date of the meeting.

50. The ICB Partners may, to such extent that they consider it appropriate, table an item at the Joint Committee relating to any other of their functions that is not a delegated function or relevant service or associated function to facilitate engagement, promote integration and collaborative working. Any decision made on such items shall not be binding on all ICB Partners unless there is full agreement.

51. The proceedings and decisions taken by the Joint Committee shall be recorded in minutes, and those minutes circulated in draft form within 28 days of the date of the meeting. The Joint Committee shall confirm those minutes at its next meeting.

Decisions and voting arrangements

52. The ICB Partners must ensure that matters requiring a decision are anticipated and that sufficient time is allowed prior to Joint Committee meetings for discussions and negotiations between them to take place.

53. The Joint Committee will make decisions through consensus wherever possible.

54. Where it has not been possible, despite the best efforts of the Members, to come to a consensus decision on any matter before the Joint Committee, the Chair(s) may defer the matter for further consideration at a later meeting or require the decision to be put to a vote in accordance with the following provision.

55. Each Member of the Joint Committee will have one vote, and a vote will be passed with a simple majority of the votes. Where a vote is tied, the proposal will not be passed.

Conduct and conflicts of interest

56. Members of the Joint Committee will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and relevant organisational policies, including:

- (a) The NHS Standards of Business Conduct policy:
<https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/>

- (b) The Nolan Principles (the Seven Principles of Public Life): <https://www.gov.uk/government/publications/the-7-principles-of-public-life>.
- (c) NHS England guidance: *Managing Conflicts of Interest in the NHS: Guidance for staff and organisations*: <https://www.england.nhs.uk/ourwork/coi/>.

57. Where any Member of the Joint Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Joint Committee, the Chair(s) will determine what action to take in accordance with NHS England guidance. This may include that Member not participating in the meeting (or relevant part of the meetings) in which the matter is to be discussed. Whatever action is agreed, the conflicted Member will not be able to take part in any decision making for the matter concerned. An ICB Partner whose Member is conflicted in this way may secure that their appointed substitute attend the meeting (or part of the meeting) in the place of that member.

Confidentiality of proceedings

58. The Joint Committee is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission to meetings of the Joint Committee is at the discretion of the ICB Partners.

59. All members in attendance at a Joint Committee are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the ICB Partners.

Variation

60. These Terms of Reference may only be varied by all ICB Partners approving the variation in accordance with their Scheme of Reservation and Delegation.

Review of the terms of reference

61. These Terms of Reference will be reviewed annually.

Approved: [Insert date of Approval by all ICB Partners]

Version Control:

Version No	Amendment	Amendment Owner	Date of Amendment
1	Original Version	N/A	

Appendix A – ICB Delegated Functions

The functions which each ICB holds, including those delegated to it by NHS England, and which form the functions for the Joint Committee to exercise are as follows:

1. Specialised commissioning and other delegated functions

A number of specialised commissioning services have been delegated to ICBs from April 2025, in accordance with the relevant Delegation and Collaboration Agreements. A sub-committee to this Joint Committee is to be established. The Terms of Reference for the specialised commissioning sub-committee are to be approved by the Joint Committee.

The commissioning of pharmacy, general ophthalmic and dental (POD) services were delegated from NHS England to the ICBs in July 2022, in accordance with the relevant Delegation Agreement. No Collaboration Agreement currently exists for POD services, and decisions are taken in accordance with individual ICB Partner Member Schemes of Reservation and Delegation (SoRD) and Standing Financial Instructions (SFIs). Joint Committee Members may make decisions relating to these services where their respective SoRD and or SFIs accommodate this. In the absence of specific commentary on these services, the level of delegated authority shall be that of the individual Joint Committee Members.

2. Collaborative commissioning at scale

There are a number of opportunities for the ICBs to collaborate in commissioning areas that are best done at a large scale and together. The initial focus is on two areas - ambulance services and mental health.

The ICB Partners already have a programme to work focusing on improving ambulance services across the south east, run by South Coast Ambulance Service NHS Foundation Trust (SECAMB) and South Central Ambulance Service NHS Foundation Trust (SCAS). There is a recently established South East Ambulance Transformation Steering Group which oversees the work being carried out to deliver long-term improvements to ambulance services.

For mental health, the ICB Partners recognise the opportunity to work together at a more strategic scale to support improvements and transformation. Working with the regional mental health board, priority areas will be identified with the aim of improving care in a more consistent way for people with a mental health condition.

Joint Committee Members may make decisions relating to these services where their respective SoRD and or SFIs accommodate this. In the absence of specific commentary on these services, the level of delegated authority shall be that of the individual Joint Committee Members.

3. Digital and data

To support the national shift towards creating an NHS that moves from 'analogue to digital', the ICB Partners are working together to build improved digital and data infrastructure. This will support greater integration and population health management to ensure patients are getting the best possible care. The initial focus is on the rollout of the Federated Data Platform (FDP) and how this will support strategic commissioning in the future.

Joint Committee Members may make decisions relating to digital and data services in accordance with their respective SoRD and or SFIs. In the absence of specific commentary on these services, the level of delegated authority shall be that of the individual Joint Committee Members.

4. Leadership and building continuous improvement culture

The ICB Partners are working together to support the work taking place to develop the best possible leadership and culture across the South East. This is focusing on improving senior leadership capability and building continuous improvement and a culture of learning.

Joint Committee Members may make decisions relating to leadership and building continuous improvement culture in accordance with their respective SoRD and or SFIs. In the absence of specific commentary on these services, the level of delegated authority shall be that of the individual Joint Committee Members.

5. Financial sustainability across the NHS

The ICB Partners recognise the financial challenge faced across all systems and the opportunities to work together where possible and where it makes sense to achieve greater financial sustainability and productivity. This will initially focus on opportunities for greater efficiency and common approaches to sustainability.

Joint Committee Members may make decisions relating to financial sustainability in accordance with their respective SoRD and or SFIs. In the absence of specific commentary on these services, the level of delegated authority shall be that of the individual Joint Committee Members.

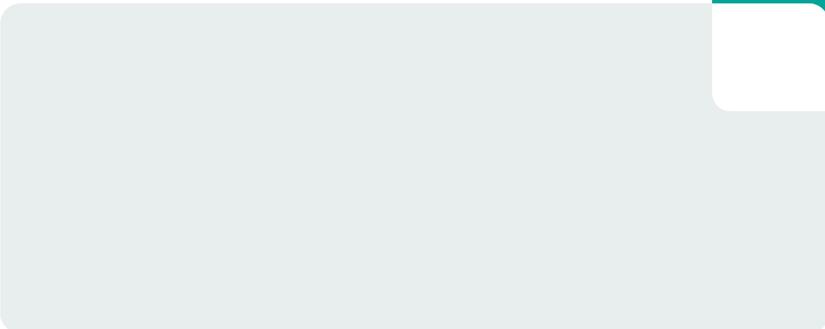
Appendix B – ICB Partners Local Terms

[Note – For ICB Partners to include such local terms, sub-committees or working groups as they deem appropriate.]

**South East Region
NHS Integrated Care Boards**

**Specialised Services
Sub-committee**

Terms of Reference



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1. Introduction and purpose

- 1.1. From April 2025, Integrated Care Boards (ICBs) entering Delegation Agreements with NHS England for specialised services will become responsible for commissioning the Delegated Specialised Services set out in Schedule 2 of the Delegation Agreement.
- 1.2. The Delegation Agreement requires ICBs to form an appropriate multi-ICB arrangement to ensure that the Delegated Specialised Services are commissioned at the most efficient and effective level for each Specialised Service.
- 1.3. The south east region ICBs have agreed for these arrangements to be overseen by the ICB Chief Executives Joint Committee. The Joint Committee will oversee the joint working arrangements, supporting the Partners to collaboratively make decisions on the planning and delivery of the in-scope Delegated Specialised Services. For this purpose, the Joint Committee will be supported by a Specialised Commissioning Services Sub-committee (the 'Sub-committee').
- 1.4. These Terms of Reference are for this Sub-committee. The Terms of Reference are intended to support effective collaboration between ICBs acting through multi-ICB arrangements to plan and deliver delegated specialised services, to ensure services are commissioned at the appropriate geographical footprint and to better align and transform pathways of care around the needs of local populations.
- 1.5. The Terms of Reference set out the role, responsibilities, membership, decision-making powers, and reporting arrangements of the Sub-committee, in accordance with the Delegation Agreements between the ICBs and NHS England, and any Agreement underpinning the multi-ICB arrangements, for example the Collaboration Agreement and Joint Committee Terms of Reference.

2. Statutory Framework

- 2.1. Section 65Z5 of the National Health Service Act 2006 (as amended) ('the NHS Act') permits NHS organisations to delegate their functions to other statutory bodies. It also permits combinations of NHS organisations to jointly exercise their functions and pool funds in a joint working arrangement.
- 2.2. In accordance with section 65Z5 of the NHS Act, ICBs can establish and maintain joint working arrangements, overseen by a Joint Committee, to jointly exercise the commissioning functions.
- 2.3. In accordance with the delegation to the Joint Committee by the ICB Partners under the Collaboration Agreement and the Delegation Agreement for Specialised Commissioning with NHS England, the Joint Committee can establish sub-committees and delegate certain functions to such sub-committees.

3. Background

- 3.1. The South East ICB Partners Specialised Services Subcommittee (The Subcommittee) will maximise the benefits to patients of integrating the delegated functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.
- 3.2. Successfully implementing the collaboration across ICB Partners will require strong relationships and an environment based on trust and collaboration; seeking to continually improve whole pathways of care for Specialised Services and to design and implement effective and efficient integration.
- 3.3. In achieving these aims, the Sub-committee will be required to act in a timely manner; to share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risks and reduce cost. In addition, the Sub-committee will be required to act at all times in accordance with the relevant Delegation and Collaboration Agreements, and in accordance within the scope of the ICBs statutory powers.
- 3.4. To work in collaboration with NHS England in exercising the delegated functions for Specialised Commissioning.

4. Partners and geographical coverage

- 4.1. The Sub-committee will have oversight of delegated specialised services accessed by the populations residing in the following geographical areas:
 - a) NHS Buckinghamshire Oxfordshire & Berkshire West ICB.
 - b) NHS Frimley ICB
 - c) NHS Hampshire & Isle Of Wight ICB
 - d) NHS Kent & Medway ICB
 - e) NHS Surrey Heartlands ICB
 - f) NHS Sussex ICB

5. Role of the Sub-committee

- 5.1. In relation to Delegated Specialised Services, the Joint Committee has delegated authority from ICB Partners for strategic decision-making, leadership and oversight in terms of agreeing related strategies and objectives, oversight of performance to ensure achievement of these objectives, and providing the appropriate assurance to ICB Boards and NHS England.

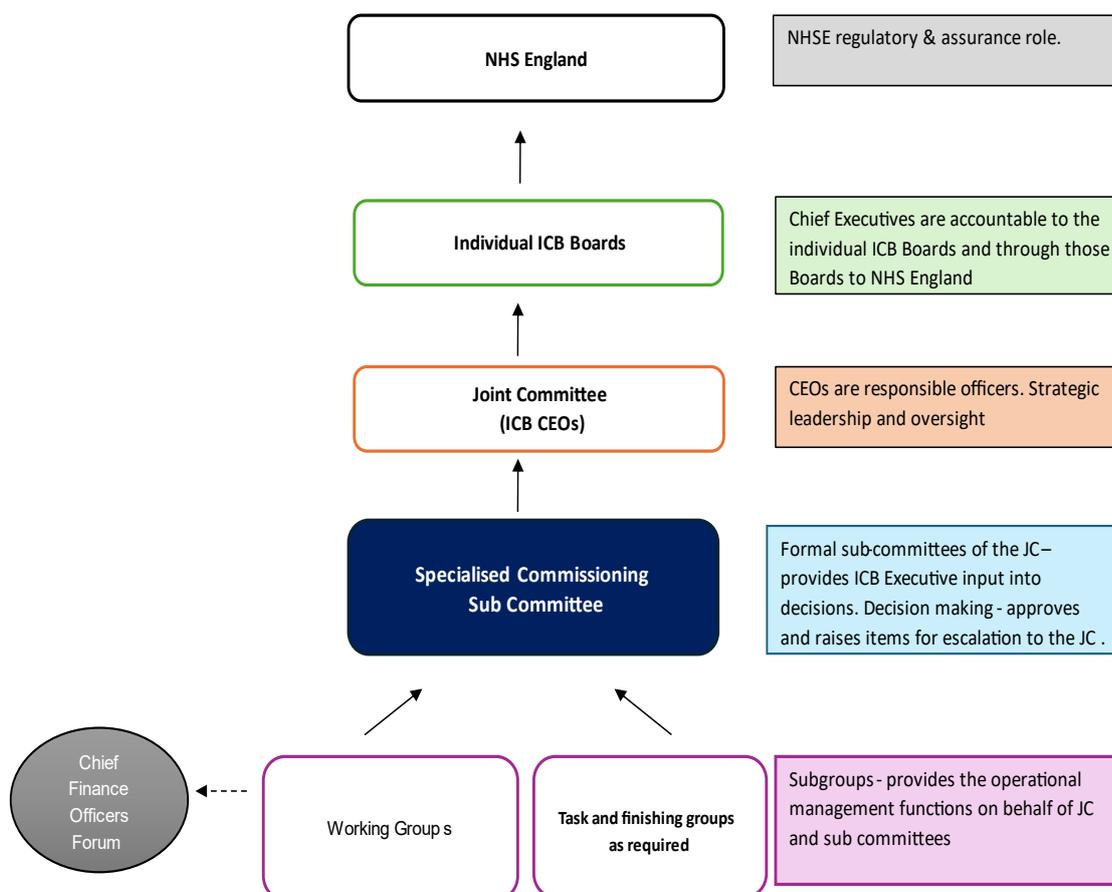
- 5.2. The Sub-committee has delegated authority from the Joint Committee to ensure effective plans are in place to deliver the agreed strategies and objectives determined by the Joint Committee relating to the commissioning of specified Delegated Specialised Services and such ICB functions as agreed by the ICB Partners and as directed by the Joint Committee.
- 5.3. This includes:
- 5.3.1. Making joint decisions in relation to the planning and commissioning of the relevant Delegated Specialised Services, and any associated commissioning or statutory functions, for the population, for example, through undertaking population needs assessments;
 - 5.3.2. Have due regard to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources in all decision-making;
 - 5.3.3. Monitoring and delivering the population-based specialised service financial allocation and financial plans for services commissioned at the multi-ICB level, including agreeing the annual contribution made by each ICB Partner, and any commissioning intentions;
 - 5.3.4. Oversight and assurance of the Delegated Specialised Services in relation to quality, operational and financial performance, including co-ordinating risk and issue management and escalation, and developing the approach to intervention with Specialised Services Providers where there are quality or contractual issues;
 - 5.3.5. Identifying and setting strategic priorities and undertaking ongoing assessment and review of Delegated Specialised Services within the remit of the Sub-committee, including tackling unequal outcomes and access;
 - 5.3.6. Supporting the development of partnership and integration arrangements with other health and care bodies that facilitate population health management and, providing a forum that enables collaboration to integrate service pathways, improve population health and services, and reduce health inequalities. This includes establishing links and working effectively with health and care partners including Provider Collaboratives and cancer alliances, other ICBs, Joint Committees and NHS England where there are cross-border patient flows to providers, in particular retained services, London and the SW regions;
 - 5.3.7. Ensuring the committee has appropriate clinical advice and leadership, including through Clinical Reference Groups and Relevant Clinical Networks;

- 5.3.8. Ensuring the Sub-committee has effective engagement with stakeholders, including patients and the public, and involving them in decision-making where necessary;
 - 5.3.9. Commencing longer-term planning of the Delegated Specialised Services, including the opportunities for transformation and integration of the services and functions by way of a clinical strategy;
 - 5.3.10. Discussing any relevant matter which any member of the Sub-committee believes to be of such importance that it should be brought to the attention of the Joint Committee or Sub-committee;
 - 5.3.11. Review and make recommendations to the Joint Committee on the operation of these terms of reference annually, subject to the terms of any existing contractual commitments and national planning guidance;
 - 5.3.12. Otherwise ensuring that the roles and responsibilities set out in the Agreement between the Partners are discharged.
- 5.4. The Sub-committee will have delegated authority from the Joint Committee to make decisions and oversee the smooth running of the delegated services on its behalf. The Sub-committee will assure the Joint Committee on a regular basis of its progress and escalate material decisions to the Joint Committee where necessary
 - 5.5. The Sub-committee will liaise with the South Retained Geographical Unit (RGU) Team as necessary, to enable the smooth running and continuity of shared matters and delegated ICB Partners responsibility.
 - 5.6. The list of Delegated Services and Delegated Functions within scope of this Joint Committee are set out in Schedule 2 of the ICBs Delegation Agreements.

6. Accountability and reporting

- 6.1. The ICB Partners are accountable to NHS England for the Delegated Services and Delegated Functions through the Delegation Agreement for Specialised Services. The Sub-committee will need to assure the Joint Committee of its progress as required. The multi-ICB arrangement describes how the ICBs will collaborate to commission the Delegated Services and perform the Delegated Functions as outlined in the graphic below and the Collaboration Agreement schedules. The outline governance structure for April 2025 is a start point that may need to iterate in its transitional year - 2025/26.
- 6.2. **The proposed tiered governance model.** Details of the Sub-committee working group arrangements will be proposed and agreed by the Sub-committee during 2025.

Figure 1 – Headline Governance Arrangements



- 6.3. **How the Sub-committee reports to the ICB Boards and how the Sub-committee will be held to account by the ICBs for delivery of its functions.** The Sub-committee will report to the ICB Boards via the Joint Committee and the ICBs Authorised Officers. It will be bound by the Joint Committee as appropriate. The Officers will utilise reports designed for assuring ICB Boards on the Sub-committee’s execution of the ICBs delegated responsibility, and rationale for decisions made across the range of commissioning functions. The officers will bring any ICB challenges to the Sub-committee as necessary and for escalation to the Joint Committee if required.
- 6.4. **The links between the Sub-committee and the Specialised Commissioning team and how it will oversee performance of those functions effectively.** The Sub-committee will oversee the commissioning functions delivered by the specialised commissioning team and the Sub-committees working groups. The specialised services commissioning team are led by an executive officer who will also be a member of the Sub-committee. Any delivery issues will be raised with the team's executive lead. Escalation where necessary, will be from Sub-committee Chair to the

Joint Committee. The commissioning team will follow national policy and guidance related for all commissioning functions.

- 6.5. **How the Sub-committee will interact with NHS England. In particular, the links to NHS England's Regional Team and the Delegated Commissioning Group.**
The Sub-committee will have representation from the NHSE Regional team where necessary to aid communication, continuity and assurance of progress or challenges as needed. This may be necessary to support decision making for ICB Partners in NOF Segment three or four. The Sub-committee will also have a representative on the national Delegated Commissioning Group (DCG) for Specialised Services and report to the DCG on its proceedings when required to do so.
- 6.6. Where the National DCG requests that the Joint Committee provides information or reports on its proceedings or decisions, the ICB Partners must comply with that request within a reasonable timescale.

7. Working Groups

- 7.1. The Sub-committee may, from time to time, establish working groups of the Sub-committee to support the discharge its functions, with such terms of reference as may be agreed between them. Any working groups that are in place at the commencement of the relevant ICB Collaboration Agreement may be documented in the relevant Schedules to that Agreement.
- 7.2. All working groups will have their Terms of Reference and membership approved by the Sub-committee and will need to operate in accordance with any requirements specified by the Sub-committee.

8. Membership

Core membership

- 8.1. Members of the Sub-committee do not need to be members of the Joint Committee.
- 8.2. Each ICB that is partner to the ICB Collaboration Agreement must nominate one Authorised Officer to be their core representative at meetings of the Sub-committee. The Authorised Officers nominated by the ICBs and present at a meeting of the Sub-committee will be voting members of the Committee.
- 8.3. ICB Partners will ensure that the Sub-committee core membership includes at least two senior clinical professionals to ensure appropriate clinical oversight and leadership of the Sub-committee.
- 8.4. Each of the ICB Partners may nominate a named substitute to attend meetings of the Committee if its Authorised Officer is unavailable or unable to attend or because they are conflicted.

- 8.5. Each of the ICB Partners must ensure that its Authorised Officer (and any named substitute) is of a suitable level of seniority and duly authorised to act on its behalf and to agree to be bound by the final position or decision taken at any meeting of the Sub-committee.
- 8.6. The Authorised Officers (or any substitute(s) appointed) form the Core Membership of the Sub-committee.
- 8.7. The Senior Team of the Specialised Commissioning Hub Team will also be Core Members of the Sub Committee, with a with a minimum of two members required to be present for the meeting to be considered quorate. They will collectively have a single vote.
- Regional Director of Commissioning
 - Director of Specialised Commissioning and Health & Justice
 - Director of Commissioning Finance
 - Director of Commissioning Nursing
 - Regional Medical Director of Commissioning
- 8.8. NHS England may appoint an officer to attend the Sub-committee and where required direct ICB Partner Members who are in National Oversight Framework (NOF) levels 3 or 4 in accordance with national direction and the relevant Delegation and Collaboration Agreements.

Attendees and discretionary or non-core members

- 8.9. The ICB Partners may identify individuals from their own organisations or other organisations to observe proceedings, contribute to the Sub-committees deliberations and provide advice to the Sub-committee, as required. These individuals will attend the Sub-committee in an advisory capacity only.
- 8.10. Such attendees will need to be agreed with the Chair of the Sub-committee in advance of the meeting.
- 8.11. The following organisations representatives are discretionary or non-core members:
- NHSE South East Region.
 - London Region ICBs.
 - SW Region ICBs.
 - Other ad hoc partners as deemed necessary by the Sub-committee to deliver its business.

- 8.12. Discretionary or non-core members from organisations stated in paragraph 8.10 may attend meetings and contribute to the Sub-committees deliberations, but these representatives will not have a right to vote.

Term of membership

- 8.13. Each of the Core Members (and any substitute appointed) will hold their appointment for a term of one year. The term of appointment of each member expires on the first anniversary of the first Sub-committee meeting at which the member is in attendance. Members will be eligible to be reappointed for further terms at the discretion of the ICB Partners. This will be confirmed by exception – i.e. those who are not continuing on the committee to be announced annually.

Membership lists

- 8.14. The Chair (or in the absence of a Chair, the ICB Partners themselves) shall ensure that there is prepared and up-to-date list of all Members (core, discretionary and non-core) and any other regular attendees, and that this list is made available to the Partners. The commissioning team administration support will review this as necessary or as directed by the Chair.

9. Chair

- 9.1. When approving the Sub-committee's terms of reference the Joint Committee will appoint one of their voting members to be the Chair of the Sub-committee. The Chair of the Sub-committee will not have any voting rights.
- 9.2. At the first meeting of the Sub-committee, the Core Membership shall select a Vice Chair from among the membership.
- 9.3. The Chair(s) shall hold office for such period, not exceeding 3 years, that the Joint Committee shall determine in approving the Sub-committee's terms of reference.
- 9.4. If the Chair is not in attendance at a meeting, the Vice Chair shall take the chair and should neither be present due to conflicts of interest, then the Core Membership will select one of the members to take the chair for that meeting.

10. Meeting arrangements

- 10.1. The Sub-committee shall plan to meet 4 times per year.
- 10.2. At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Sub-committee shall prepare a schedule of meetings for the

forthcoming year (“the Schedule”) as well as confirming the membership and any regular attendees.

- 10.3. The Chair (or in the absence of a Chair, the core members) shall see that the Schedule is notified to the members.
- 10.4. The ICB Partners (individually or collectively) may call for an extraordinary meeting of the Sub-Committee outside of the Schedule as they see fit, by giving notice of their request to the Chair. The Chair may, following consultation with the ICB Partners, confirm the date on which the extraordinary meeting is to be held and then issue a notice giving not less than seven working days’ notice of the extraordinary meeting.

11. Levels of Delegated Authority

- 11.1. The level of delegated authority the Sub-committee shall have for decision making, shall be explicitly determined by the Joint Committee and shall not exceed the level of authority of the Joint Committee. Where the Joint Committee has not explicitly determined a level of delegated authority for the Sub-committee, the level of delegated authority for each of the Sub-committee Members will be in accordance with their respective ICB Scheme of Reservation and Delegation and Standing Financial Instructions.

12. Quorum

- 12.1. A Sub-committee meeting will be quorate with the following persons present:
 - 12.1.1. a minimum of four of the ICB Partner Authorised Officers (or substitutes);
and
 - 12.1.2. a minimum of two members of the Senior Team of the Specialised Commissioning Hub Team
- 12.2. The Sub-committee Chair or vice Chair should also be present at the meeting for it to be quorate unless both are conflicted, in which case the provisions of paragraph 9.4 shall apply.

13. Secretariat functions

- 13.1. The Specialised Commissioning Team shall provide sufficient resources, administration and secretarial support to ensure the proper organisation and functioning of the Specialised Commissioning Sub- Committee.

14. Publication of notices, minutes and papers

- 14.1. In accordance with good governance practices, publication of the papers and minutes should be considered for the purposes of transparency and accountability.

The publication of papers and minutes need not be in advance of the meeting and may be limited, for example, to formal decisions made.

- 14.2. The Chair (or in the absence of a Chair, the ICB Partners themselves) shall see that notices of meetings of the Committee, together with an agenda listing the business to be conducted and supporting documentation, is issued to the Sub-committee members and any regular attendees one week prior to the date of the meeting.
- 14.3. Committee members may, to such extent that they consider it appropriate, table an item at the Sub-committee relating to any other of their functions that is not a Delegated Specialised Service but will impact the delivery or associated function of Delegated Specialised Service. This is to facilitate engagement, promote integration and collaborative working across the pathway. This is particularly important when considering communication and continuity of business and decision making with the South Retained Services Team on retained Specialised Services.
- 14.4. The proceedings and decisions taken by the Sub-committee shall be recorded in minutes, and those minutes circulated in draft form within one week of the date of the meeting. The Sub-committee shall confirm those minutes at its next meeting and make them available to the Joint Committee.

15. Decisions and voting arrangements

- 15.1. The aim of the Sub-committee will be to achieve consensus decision-making wherever possible, and decisions made by Sub-committee will be consistent with the powers provided to it within the Collaboration Agreement.
- 15.2. The ICB Partners must ensure that matters requiring a decision are anticipated and that sufficient time is allowed prior to Sub-committee meetings for discussions and negotiations between ICB Partners to take place.
- 15.3. Where it has not been possible, despite the best efforts of the Core Membership, to come to a consensus decision on any matter before the Sub-committee, the Chair(s) may determine to delay the matter until the next meeting to try and obtain consensus, refer the matter to the Joint Committee for a decision, or require the decision to be put to a vote in accordance with the following provision.
- 15.4. Each of the ICB Authorised Officers (or their substitute) present at a meeting of the Sub-committee will have one vote. The Senior Team of the Specialised Commissioning Hub will collectively also have one vote. A vote will be passed with a simple majority of the votes of core members present. In the event of a tied decision the proposal will not be approved.
- 15.5. Should the Sub-committee determine a specific matter should be referred to the Joint Committee then the Chair will do so within 48 hours of that decision being made and inform the Joint Committee of the reasons for the referral to them.

16. Conduct and conflicts of interest

- 16.1. Members of the Sub-committee will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and relevant organisational policies.
- 16.2. The NHS Standards of Business Conduct policy is available from:
<https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/>
- 16.3. Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life). See: <https://www.gov.uk/government/publications/the-7-principles-of-public-life>.
- 16.4. Members should refer to and act consistently with the NHS England guidance: *Managing Conflicts of Interest in the NHS: Guidance for staff and organisations*. See: <https://www.england.nhs.uk/ourwork/coi/>.
- 16.5. Where any Member of the Sub-committee has an actual or potential conflict of interest in relation to any matter under consideration by the Sub-committee, the Chair will determine what action to take in accordance with NHS England guidance. This may include that Member not participating in the meeting (or relevant part of the meeting) in which the matter is to be discussed. Whatever action is agreed, the conflicted Member will not be able to take part in any decision making for the matter concerned. An ICB Partner whose Member is conflicted in this way may secure that their appointed substitute attend the meeting (or part of the meeting) in the place of that member.
- 16.6. The Chair must manage conflicts of interest in accordance with published guidance for the NHS.

17. Confidentiality of proceedings

- 17.1. The Sub-committee is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission to meetings of the Sub-committee is at the discretion of the ICB Partners.
- 17.2. All members in attendance at the Sub-committee are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the ICB Partners.

18. Review of the Terms of Reference

- 18.1. These Terms of Reference will be reviewed annually, with any proposed changes recommended to the Joint Committee for their approval.

Approved:

[Insert date of Approval by the Joint Committee]

Version Control:

Version No	Amendment	Amendment Owner	Date of Amendment
1	Original Version	N/A	

ANNEX A: Membership List

	Name	Role/Title	Membership	Organisation
1	Mark Atkinson	Director of Performance Delivery	Core	Kent and Medway ICB
2	Andy Rhodes	Chief Medical Officer	Core	Surrey ICB
3	Jessica Britton	Executive Managing Director – Sussex-wide Complex Commissioning	Core	Sussex ICB
4	Lyn Darby	Director of Acute Commissioning	Core	HIOW ICB
5	Sam Burrows	Director of Strategy	Core	Frimley ICB
6	Hannah Iqbal	TBC	Core	BOB ICB
7	Caroline Reid	Regional Director of Commissioning NHSE SE Region	Core	ICB Specialised Commissioning Team.
8	David Barron	Director of Specialised Commissioning and Health and Justice NHSE SE Region	Core	ICB Specialised Commissioning Team.
9	Mel Shipton	Director of Commissioning Finance – South East Region	Core	ICB Specialised Commissioning Team.
10	Chris Tibbs	Medical Director Specialised Services NHSE SE Region	Core	ICB Specialised Commissioning Team.
11	Rosie Baur	Director of Nursing & Quality	Core	ICB Specialised Commissioning Team.

	Discretionary Attendees	Role/Title	Membership	Organisation
12	Sadaf Dhalabhoy	Deputy Director Delegation, Contracts and Performance.	Discretionary attendee	ICB Specialised Commissioning Team.
13	Janette Harper	Deputy Director of Transformation & Recovery Specialised Commissioning.	Discretionary attendee	ICB Specialised Commissioning Team.
14	Hazel Fisher		Discretionary attendee	London Partnership Board
15	Tim Moran	Delegation Programme Lead - NHSE SE Region	Discretionary attendee	ICB Specialised Commissioning Team.
16	Luke Culverwell	Deputy Director of Specialised Commissioning NHS England South-West Region.	Discretionary attendee	SW Partnership Board

