NHS North East London Integrated Care Board

Governance Handbook

Version	Effective Date	Changes
V1.0	1 July 2022	
V2.0	22 November 2022	Decision making principles included All terms of reference updated following meetings with committee leads, ICB chair and chief executive All policies updated with new guidance from NHS England
V3.0	29 November 2023	Terms of reference for the Acute Provider Collaborative Joint Committee. Standing Financial Instructions updated.

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1 Introduction

1.1 Purpose of the Handbook

1.1.1 The Governance Handbook ("the Handbook") for NHS North East London Integrated Care Board ("the ICB") brings together key documents which support the Constitution and promote good governance. This Handbook contains practical details for applying the Constitution including:

a) Scheme of Reservation and Delegation ("SoRD")

b) Standing Financial Instructions ("SFI") and Financial Scheme of Delegation

c) Terms of reference for committees

d) Governance policies

e) Delegation agreements.

1.1.2 This Handbook is not a legal requirement, but will assist the ICB to build a consistent corporate approach and form part of its corporate memory.

1.1.3 If there is any ambiguity between the Constitution and this Handbook, the interpretation in the Constitution will apply.

1.1.4 This Handbook is maintained by the ICB's Governance Team and will be updated as contents are amended and will be reviewed annually.

1.1.5 This Handbook will be published on the ICB's public website on the same page as the Constitution.

Part 1: NHS North East London health and care system

2 Integrated Care Systems

2.1.1 Integrated Care Systems (ICS) are partnerships that bring together NHS organisations, primary care, local authorities, the voluntary and community sector and other local partners within a geographical area to collectively plan health and care services to meet the needs of its local population.

2.1.2 NHS England has set out the following four purposes of ICSs as follows:

a) Improve outcomes in population health and healthcare;

b) Tackle inequalities in outcomes, experience, and access;

c) Enhance productivity and value for money; and

d) Help the NHS support broader social and economic development.

2.1.3 The NHS Long Term Plan set the ambition that every part of England would become an ICS by 2021. Whilst ICSs have been operating since 2021, with some evolving from Sustainability and Transformation Partnerships, they became established on a statutory footing on 1 July 2022 following the passage of the Health and Care Act 2022 and the creation of Integrated Care Boards.

2.1.4 Expectations for ICSs are also set out a suite of policies and guidance, published mainly by NHS England. These are found here: NHS England » Key documents for Integrated Care Systems

3 Overview of North East London Integrated Care System

3.1 Our ICS purpose, principles and priorities

3.1.1 Our collective purpose states: "We will work with and for all the people of north east London to create meaningful improvements in health, wellbeing and equity."

3.1.2 We will design and operate the NEL ICS in a way that:

- Improve quality and outcomes
- Secures greater equity
- Creates value
- Deepens collaboration

3.1.3 Our flagship priorities are:

- Babies, children and young people – to make NEL the best place to grow up
- Mental health – to improve the mental health and wellbeing of the people of NEL
- Employment and workforce – to create meaningful work opportunities for people in NEL
- Long-term conditions – to support everyone living with a long-term condition in NEL to live a longer, healthier life

3.2 Integrated Care Board

3.2.1 The ICS is coordinated by the ICB, an NHS Body, along with a broader Integrated Care Partnership ("ICP") – see section 3.3 for further details on the ICP.

3.2.2 The ICB will be responsible for specific functions that enable it to deliver against the core purposes, as follows:

a) Developing a plan to meet the health needs of the population within its area, having regard to the ICP's integrated care strategy;

b) Allocating resources to deliver the plan across the system;

c) Establishing joint working arrangements with partners that embed collaboration as the basis for delivery of joint priorities within the plan;

d) Establishing governance arrangements to support collective accountability;

e) Arranging for the provision of health services;

f) Leading system-wide action on data and digital;

g) Understanding local priorities, tracking delivery plans, monitoring and addressing variation and driving continuous improvement;

h) Investing in local community organisations and infrastructure;

i) Driving joint work on estates, procurement, supply chain and commercial strategies;

j) Planning for, responding to and leading recovery from incidents.

3.2.3 The ICB has taken on all of the NEL CCG's functions and duties, in addition to new ones. The core functions are reflected in its Scheme of Delegation and Reservation ('SoRD') and summarised in the governance chart or map.

3.2.4 The membership of the Board of the ICB is set out in Section 4 of this Handbook.

3.3 Integrated Care Partnership

3.3.1 The Integrated Care Partnership ("ICP") is a joint committee of the ICB with the local authorities whose areas fall wholly or partly within the ICB's area. The ICP is responsible for developing an integrated care strategy to address the health and social care needs within the whole area of the ICB, including determinants of health.

3.3.2 In NEL local authority and NHS partners have agreed to establish a smaller 'steering group', comprised of system partner leaders, to coordinate the work of the ICP.

3.3.3 The Terms of Reference for the ICP and its steering group can be found here.

3.4 Wider ICB and ICS system architecture

3.4.1 There are other important parts of the system architecture which contribute to the work of the ICS and operate across different footprints within the ICB's area. These all interact and work within a matrix approach, with for example provider colleagues as full members of place-based partnerships. Our system operates with a principle of subsidiary, with decision making happening as close to people and locally as possible. The key elements of the system are:

a) **Place Based Partnerships.** Places are geographical areas which serve hundreds of thousands of people. Place Based Partnerships operate at place level and are responsible for delivering the core aims of the ICS, along with their own local priorities.

b) **Provider Collaboratives.** Provider Collaboratives work at 'system level' (i.e. across North East London) and are responsible for delivering the core aims of the ICS.

c) **Primary Care Networks (PCNs).** PCNs bring together General Practice and other primary care services, such as community pharmacy, to provide a wide range of services at neighbourhood level.

4 North East London Integrated Care Board

4.1 Membership

4.1.1 Membership of the Board of the ICB comprises of the following:

- Chair;
- Chief Executive;
- two Partner Members (NHS trusts and foundation trusts);
- two Partner Members (primary medical services);
- two Partner Members (local authorities);
- Chief Finance and Performance Officer;
- The role fulfilling that of ICB Medical Director;
- Chief Nursing Officer;
- three Independent Non-executive Members;
- Voluntary, Community and Social Enterprise (VCSE) member.

4.1.2 Information about the individuals who fulfil these roles can be found at https://northeastlondon.icb.nhs.uk/about-the-north-east-london/our-board/

4.1.3 Participant observers of the Board of the ICB comprises of the following:

- Healthwatch representative
- Two local authority Chief Executive Officers
- Chief Participation and Place Officer
- Chief People and Culture Officer
- Chief Strategy and Transformation Officer

4.2 ICB priorities/objectives

4.2.1 In year one we I set foundations for our strategic objectives through establishing:

- The five-year strategy for the ICB plus a clear approach to the four priorities that bring the whole system together, with a clear framework for wider strategy development including addressing population growth;
- A shared approach to population health with an approach to data and the digital infrastructure to support this, and enable us to tackle inequalities;

- The policies we will need as an ICB to achieve our aims;
- Governance that enables and supports integration and focusses our collective effort on our objectives.
- A finance strategy which supports us to work as a system including a three-year medium term financial strategy (MTFS), and with a focus on sustainability.

4.3 Decision making principles and code of conduct

4.3.1 ICB Board members have agreed a set of principles for decision making. Board, committee, ICP and staff are expected to conduct business in line with the following:

- Always put the best interests of all the residents of north east London first within a culture where our residents are our partners and co-production is universally applied
- Proactively tackle health inequities in access, experience and outcomes. Demonstrably consider the equality, diversity and inclusion implications of the decisions we make
- Bring our experience and sector perspective, rather than representing the individual interests of any member organisation or place over those of another.
- Be open and transparent, including when we have challenges, and ensure our communities can hold us to account for delivery. Though this provide constructive challenge, but always remain 'solution-focused'
- Create a culture of creativity, innovation, improvement and inspiration, enabling transformation for better outcomes with our people and communities
- Be brave and ambitious for our communities, while ensuring we are grounded and realistic. In doing this consider risks and mitigations carefully, but not be risk averse where we believe we can make improvements for local people
- Support distributed leadership and decision making – close to people – being outcome focused whilst assuring performance.
- Demonstrate and enable collaboration, mutual accountability, shared learning, embedding of best practice and joint development.
- Secure the best value and benefit from our collective resources, maximising productivity.

4.3.2 The 'Standards of Business Conduct and Conflicts of Interest Policy' which can be found here sets out the expectations for all Board members and staff.

4.3.3 A number of nationally published documents set out the code of conduct for NHS and/or public body board members. These have not currently been updated to reflect the Boards of ICBs, which have a different composition, including partner members nominated from their sector. The most recently updated document setting out expectations can be found here: Code of Conduct for Board Members of Public Bodies June 2019. The majority of the content applies to ICB Board members; however, it must be noted that section 3.11 does not apply to local government partner members, who can also be elected members.

5 Overview of North East London Committees

5.1 Committees

5.1.1 The ICB has established a number of committees to assist it with the oversight, assurance and delivery of its functions. A summary of the committees can be found below.

- Executive Committee
- Audit and Risk Committee
- Finance, Performance and Investment Committee
- Population Health and Integration Committee
- Quality, Safety and Improvement Committee
- Workforce and Remuneration Committee[1]

5.1.2 The ICB has also established a number of sub-committees which feed into the Population Health and Integration Committee for each Place and Provider Collaborative. These are described further in the next sections. In addition, a Primary Care Contracts Group has been established reporting to the Finance Performance and Investment Committee and a Clinical Advisory Group reporting to the Executive Committee.

[1] Non-Executive Remuneration Committee to meet as required

6 Overview of NEL's seven Place-Based Partnerships

6.1.1 *Thriving places* positions Places as the foundation for an ICS, responsible for arranging and delivering health and care services in a locality or community.

6.1.2 Each Place is comprised of partnerships that bring together NHS organisations, primary care, local authorities, the voluntary and community sector and other local partners within a geographical area to collectively plan health and care services to meet the needs of its local population.

6.1.3 The ICS is made up of seven places. Each place-based partnership operates in a place area coterminous with usually one local authority (but in the case of City and Hackney two). The decision-making structure comprises a broader place-based partnership board, which meets in common with an ICB Place Sub-committee. Those Place Based Partnerships operate alongside Health and Wellbeing Boards, and in total there are 49 Primary Care Networks across the seven Places.

6.1.4 The seven places making up our ICS are shown in the map below:

6.1.5 Place based partnership boards and sub-committees include clinical, local authority, trust, ICB, voluntary sector and resident/patient group members and participants.

6.1.6 The core aims of Place are to:

a) Improve the health and wellbeing of the population and reduce inequalities;

b) Provide consistent, high quality services that remove unwarranted variation in outcomes;

c) Consistently achieve national standards and targets across the sectors; and

d) Maximise the use of place-based financial allocation and resources.

6.1.7 As a system we are also aligned to the regional priorities through the London Health and Care Partnership and London Health Board, underpinned by the London Health and Care Vision which sets out 10 key areas of joint work to improve the health of Londoners.

7 Overview of Provider Collaboratives

7.1.1 Provider Collaboratives are partnership arrangements, between our NHS Providers, local authority partners, voluntary and independent sector providers, and resident/patient group partners, supporting Systems to deliver strategic priorities.

7.1.2 Provider collaboratives are established with the following core aims of:

a) Reducing unwarranted variation and inequality in health outcomes, access to services and experience;

b) Improving resilience by, for example, providing mutual aid;

c) Ensuring that specialisation and consolidation occur where this will provide better outcomes and values.

7.1.3 The ICB has established a number of provider collaborative ICB committees in year one which will evolve as we test the system and as further delegation is permitted:

a) Acute Provider Collaborative Joint Committee;

b) Mental Health, Learning Disability and Autism Collaborative Committee;

c) Primary Care Collaborative Committee;

d) Community Provider Collaborative

7.1.4 The Acute Provider Collaborative is now established as a Joint Committee which will carry out delegated functions from both the Board of the ICB and the Boards of the acute Trusts with respect to planning, leadership, engagement and governance.

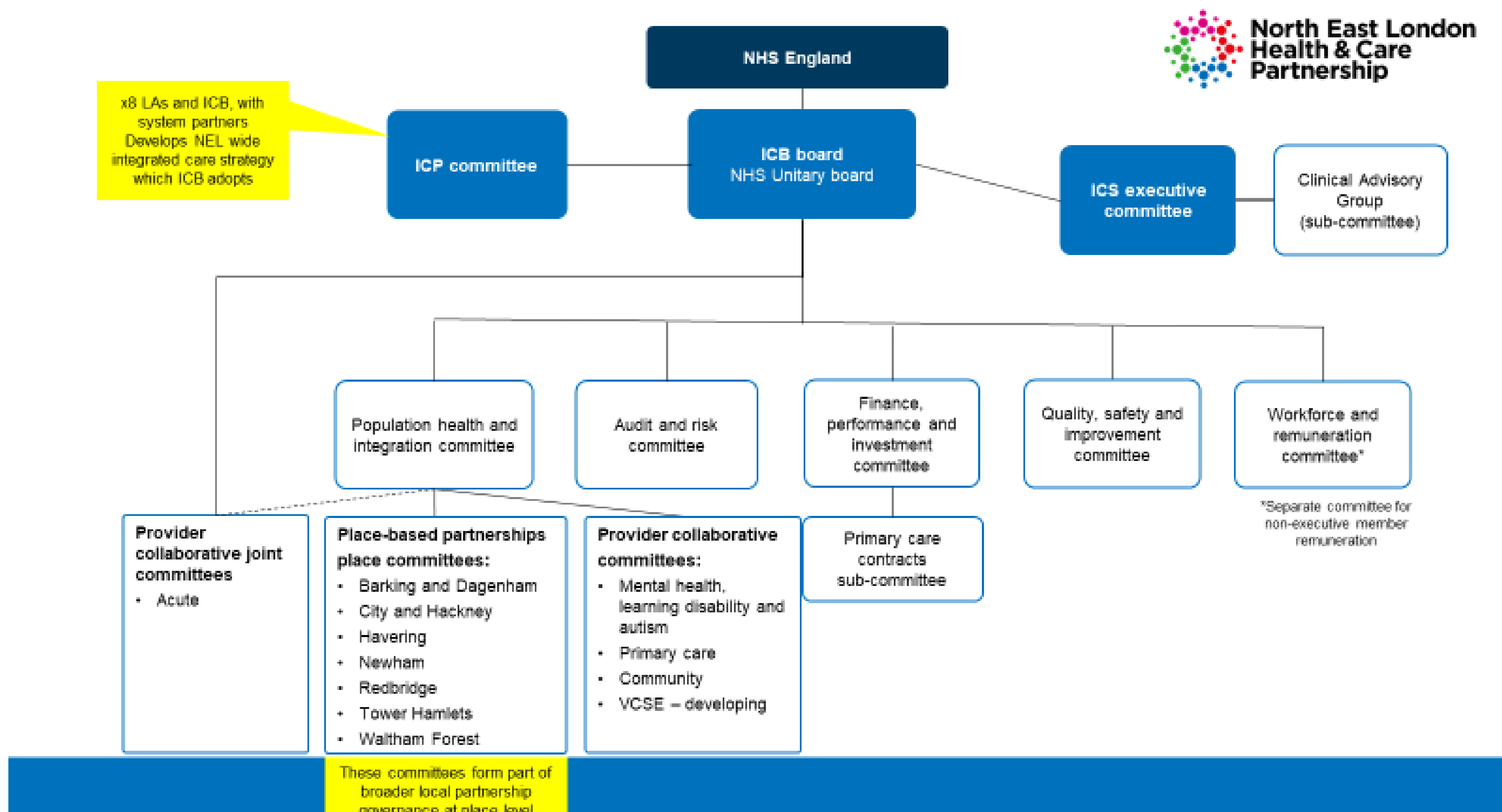
7.1.5 Work is underway with the Voluntary, Community and Social Enterprise (VCSE) Collaborative to fully establish associated governance. This is a key feature of our system arrangements given we are a national pilot for developing such a collaborative. The collaborative is due to formally commence in 2024.

Part 2: Functions and Decision Making

8 Governance, including high level functions and decision map

8.1.1 The map, or chart on the following page sets out at a high level the structure of governance for the ICS and ICB, including a summary of the purpose for each element. The scheme of reservation and delegation and terms of reference provide further detail.

High level governance chart



Summary of functions/responsibility for each board/committee

Governance element	High level role and purpose NB terms of reference available within governance handbook
Integrated Care Partnership ‘committee’ of ICB and LAs Coordinated by a smaller ‘steering group’	• Develops system integrated health and care strategy addressing broad health and social care needs of population, including wider determinants such as employment, environment and housing issues • Focus on NEL purpose, four priorities and commitment to participation • Facilitates mutual accountability of all ICS partners in delivery of overall strategy
Integrated Care Board (ICB) unitary board	• Statutory oversight of ICB functions (quality, finance, performance) and delivery of integrated care strategy (as above). Focus: ○ to improve access, experience and outcomes, reducing variation ○ to tackle health inequalities and ensure population health management ○ to ensure value, sustainability and productivity
ICS executive committee	• ICB and ICS executives (with delegated authority from their organisations) oversight of operational delivery • Review of strategy, performance etc prior to recommendation to board
Audit and risk committee	• Provides independent and objective assurance on system of internal control, governance and risk management
Finance, performance and investment committee	• Finance and performance oversight for system 9financial allocation comes to ICB), including investment decisions
Population health and integration committee	• Takes on delegation of commissioning function from ICB board • Delegates to place/provider committees – ensures appropriate division and no duplication in decision making • Ensures integration happening and health inequalities for whole population addressed
Place sub-committees	• Responsible for ICB delegated functions at place • Meets alongside/within a broader partnership responsible for broader health and care of population • Potential for join committee with ICB plus other functions (eg LA, NHS trust)
Collaborative sub-committees	• Responsible for ICB delegated functions to groups of providers (and ICB)
Joint committees	• Will carry out delegated functions from both the Board of the ICB and the Boards of the Trusts with respect to planning, leadership, engagement and governance
Quality safety and improvement committee	• Reducing clinical variation, developing appropriate clinical pathways, continuously improving access, experience and outcomes
Workforce and remuneration committee - Smaller rem com for NEM remuneration to meet as required	• Agreeing remuneration and terms of service for ICB VSMs and board, and people oversight for ICB staff • Wider oversight of workforce priority for ICS

8.1.2 Scheme of Reservation and Delegation (SoRD)

8.1.3 The SoRD, which can be found here, sets out:

a) Those functions that are reserved to the Board of the ICB;

b) Those functions that have been delegated to an individual or to committees and sub-committees;

c) Those functions delegated to another body, or to be exercised jointly with another body, under sections 65Z5, 65Z6 or 75 of the NHS 2006 Act.

8.1.4 The ICB remains accountable for all of its functions, including those it has delegated. All those with delegated authority are accountable to the Board of the ICB or relevant board committee for the exercise of their delegated functions.

8.1.5 The SoRD will be updated each time a change is proposed and agreed, and reviewed on an annual basis at the end of each financial year.

9 Standing Financial Instructions

9.1.1 The ICB has agreed a set of standing financial instructions (SFIs) which include further detail on the delegated limits of financial authority as set out in the summary finance SoRD. They can be accessed here.

9.1.2 The Finance SoRD will be updated each time a change is proposed and agreed, and reviewed on an annual basis at the end of each financial year.

10 Governance Policies

10.1.1 The ICB has developed a number of key governance policies as follows, which are widely shared with ICB staff and board members, with associated training and support available.

- Standards of business conduct and conflicts of interest policy
- Anti-fraud and bribery policy
- Freedom to Speak up policy
- Risk management policy and strategy

Other relevant policies and strategies, such as the Working with People and Communities Strategy can be found on the ICB's website