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 noted[1], 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:

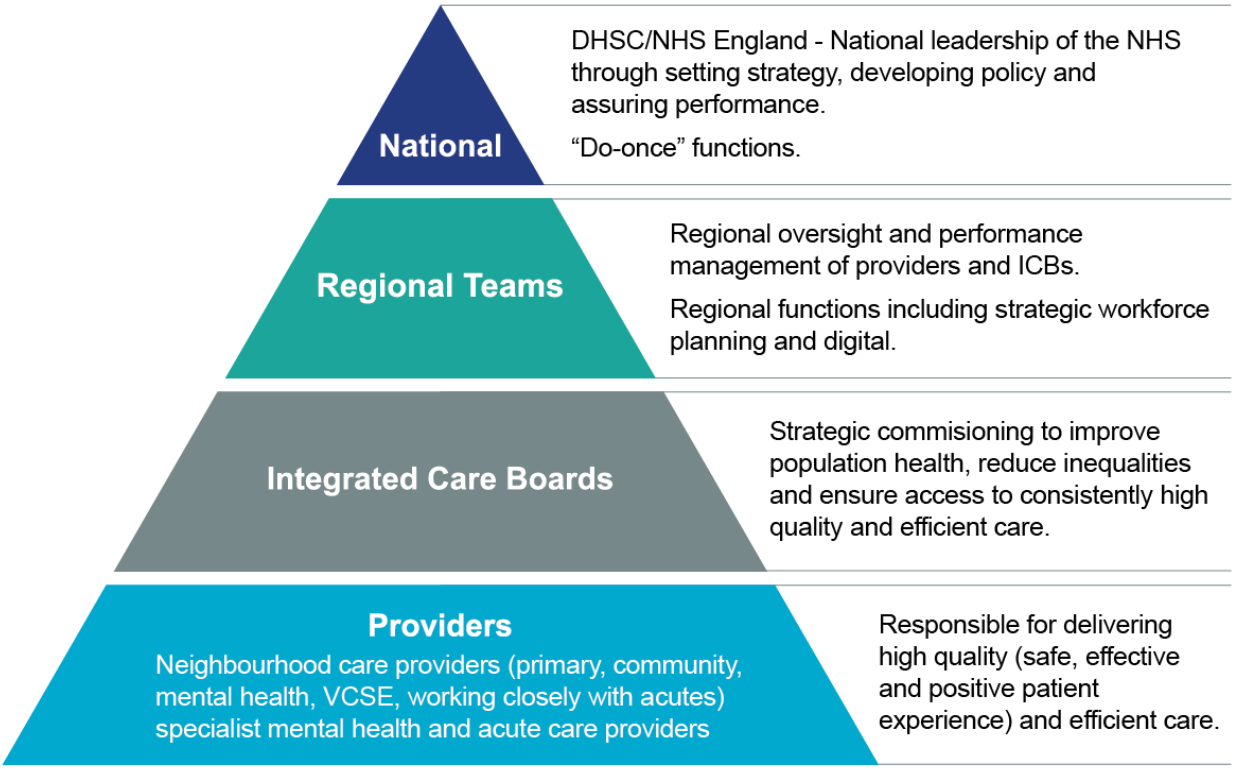
- **purpose** – why ICBs exist
- **core functions** – what they do
- **enablers and capabilities** – what needs to be in place to ensure success
- **managing transition** – supporting ICBs to manage this transition locally and the support and guidance that will be available.

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	• 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	• 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	• 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	• 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

	• 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	• 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	• 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	• 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	• 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	• 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	• 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	• 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	• 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	• 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	• 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 dis-aggregate 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) *Vaccinations and screening will be delegated by NHS England to ICBs in April 2026* *All remaining NHS England direct commissioning functions will be reviewed during 2025/26*	
	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	• 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	• 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	• 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)	• 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)	• Look to streamline and deliver some functions at scale
	Existing commissioning functions, including clinical policy and effectiveness – local funding decisions (individual funding	• 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)	• 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	• Transfer to regions over time
	High level strategic workforce planning, development, education and training	• 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	• Transfer to providers over time
	Research development and innovation	• Transfer to regions over time, with ICBs retaining and building strategic partnerships to support population health strategy
	Green plan and sustainability	• Transfer to providers over time
	Digital and technology leadership and transformation	• Transfer digital leadership to providers over time enabled by a national data and digital infrastructure
	Data collection, management and processing	• Transfer to national over time
	Infection prevention and control	• Test and explore options to streamline and transfer some activities out of ICBs

	Safeguarding	• Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	SEND	• 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	• Transfer to neighbourhood health providers over time
	Primary care operations and transformation (including primary care, medicines management, estates and workforce support)	• Transfer to neighbourhood health providers over time
	Medicines optimisation	• Transfer delivery to providers over time, retain strategic commissioning overview as part of strategy function
	Pathway and service development programmes	• Transfer to providers, retain strategic commissioning overview as part of strategy function
	NHS Continuing Healthcare	• Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	Estates and infrastructure strategy	• Transfer to providers over time, retain limited strategic commissioning overview as part of strategy function
	General Practice IT	• 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.