

Draft design principles – clinical and care professional leadership in Integrated Care Systems (ICSs)

Deadline: March 31 2021

Principle 1: It is the collective responsibility of everybody in a system to create a collaborative and permissive culture in which clinical and care professionals from the NHS, public health and social care, work in partnership with non-clinical/managerial colleagues; recognising and utilising one another's skills and using their expertise and knowledge to improve people's lives and tackle inequalities in outcomes and access.

This principle is the right one to support an ICS to develop effective clinical and care professional arrangements? (Options: Strongly agree, agree, disagree, strongly disagree)

- Strongly agree
- The Faculty of Sexual and Reproductive Healthcare (FSRH) agree that the move towards collective responsibility will encourage NHS bodies and providers to work towards improving population health outcomes and consider public health interventions in the planning and delivery of their services. We support the legislative proposals to remove the current procurement rules which apply to NHS and public health commissioners, eliminating the need for competitive tendering.
- We believe that collaborative working should be the new standard model during and beyond the pandemic. The Community Sexual and Reproductive Healthcare Specialty has been a trailblazer in this area for years. From our members' experience in designing multidisciplinary teams, we have learned that having the right skill mix, empowering all staff to develop and fostering a sense of ownership through close team working has been crucial. This results in staff feeling more valued, which reflects in the quality of care provided.

Principle 2: Clinical and care professional leadership, across the NHS, public health, and social care, is embedded at every level of the system, recognising existing structures and networks as appropriate; with clear lines of sight and connectivity between the levels, enabling meaningful dialogue and decision-making.

This principle is the right one to support an ICS to develop effective clinical and care professional arrangements? (Options: Strongly agree, agree, disagree, strongly disagree)

- Strongly agree
- Clinical leadership for women's health should be embedded at every level of the healthcare system. At national level (NHSE), accountability could be enhanced with the appointment of a National Clinical Director (NCD) for women's reproductive health or a National Specialty Adviser in Community Sexual and Reproductive Healthcare (CSRH). At system level (ICSs), accountability could be enhanced through the appointment of a women's health lead at the ICS NHS Body Board or equivalent structure. We believe that it is also crucial that a Sexual and Reproductive Healthcare lead is represented in Health and Care Partnerships' Boards.

Principle 3: Systems have clearly described mechanisms and communications processes in place which ensure full integration of clinicians and care professionals in decision-making, service change and implementation of ICS priorities. Systems will be able to evidence how this is working in practice; at every level of the system; and in all functions e.g. place;

provider collaboratives; system change, and in working with patients and local communities.

This principle is the right one to support an ICS to develop effective clinical and care professional arrangements? (Options: Strongly agree, agree, disagree, strongly disagree)

- Strongly agree

Principle 4: The work of clinicians and care professionals in leadership roles is equally valued. They need a clear understanding of the ICS strategy and priorities and require protected time and resources to undertake transformational activities. They must have access to appropriate data infrastructure, digital enablers and analytical resources, supporting a data-driven approach to decision-making and enabling them to effectively address population health need and the wider determinants of health and health inequalities.

This principle is the right one to support an ICS to develop effective clinical and care professional arrangements? (Options: Strongly agree, agree, disagree, strongly disagree)

- Strongly agree
- Clinicians and care professionals should be included in the development of ICS strategy and priorities. Clinicians and care professionals should be represented in all relevant governance bodies to ensure that their perspectives are included in all strategies.

Principle 5: Systems must create a diverse and inclusive talent pool, and adopt open, fair and equitable ways of identifying current and future leaders which encourage traditionally under-represented clinical and care profession groups to take on system leadership roles. System leaders should be champions, enthusiasts, and innovators; people who can influence, engage, and pull people together around a single, unifying purpose, based on improving health outcomes and using population health management techniques.

This principle is the right one to support an ICS to develop effective clinical and care professional arrangements? (Options: Strongly agree, agree, disagree, strongly disagree)

- Strongly agree

Principle 6: Systems will have a clearly defined support offer that recognises the different skill set, behaviours and relationships required when working effectively across organisational and professional boundaries; a clear training and development plan for clinical and professional leaders at all levels to enable them to work effectively in system roles, and clear signposting to those local, regional, and national support offers which clinical and professional leaders in systems can access.

This principle is the right one to support an ICS to develop effective clinical and care professional arrangements? (Options: Strongly agree, agree, disagree, strongly disagree)

- Strongly agree

Principle 7: Systems should adopt a ‘learning system’ approach, supporting a culture of continuous learning, in which measuring the effectiveness of their clinical and care professional leadership arrangements, and adapting their approach based on what is/is not working well, is considered business as usual.

This principle is the right one to support an ICS to develop effective clinical and care professional arrangements? (Options: Strongly agree, agree, disagree, strongly disagree)

- Strongly agree

*** 8. Are there any additional principles that you believe are key to ensuring the development of effective clinical and care professional arrangements in an ICS?**

- We believe that there should be an additional principle around transparency in workforce planning. Workforce is the biggest challenge to the sustainability of the NHS. The DHSC’s White Paper “Integration and Innovation: working together to improve health and social care” includes a proposal to create a duty for the Secretary of State for Health and Social Care to publish a document setting out roles and responsibilities for workforce planning and supply each Parliament. However, this proposal does not ensure transparency or accountability. We believe that to provide transparency, workforce data and planning should be published annually, with a legal duty on a relevant body to do this (such as Health Education England). In addition, to provide accountability, there should be a legal duty for the Secretary of State for Health and Social Care to respond to that publication annually in Parliament. It is imperative that a long-term workforce strategy is developed, reported on annually and provided with sufficient funding to enable implementation.
- In sum, a national drive to get workforce supply and planning right is needed to support the establishment of professional leadership arrangements in ICSs and achieve the right balance in terms of representation of the medical and non-medical professions. It will be challenging to ensure clinical leaders are represented if the right supply numbers are not there in the first place, and professionals are not supported with training to develop leadership skills.

*** 9. The draft principles above will ensure that clinical and care professional arrangements in an ICS are inclusive of a wide range of disciplines across health and local government partners**

- Strongly agree

*** 10. In your view, how important is it to be prescriptive about how an ICS complies with each of the principles to ‘make them stick’ e.g., by mandating structures and mechanisms for clinical and care professional arrangements.**

- Very important
- We believe that voluntary arrangements will not tackle the systemic variation of service quality and outcomes. Clinical leadership is needed to ensure that ICS can collaborate effectively. Clinical leadership for women’s health should be embedded at every level of the system. At national level (NHSE), accountability could be enhanced with the appointment of a National Clinical Director (NCD) for women’s reproductive health or a National Specialty Adviser in Community Sexual and Reproductive Healthcare (CSRH). At system level (ICSs), accountability would be enhanced through the appointment of a women’s health lead at the ICS NHS Body Board or equivalent structure. We believe that it is also crucial that a Sexual and Reproductive Healthcare lead is represented in Health & Care Partnerships’ Boards.

11. Does your system embody any of the principles already? If so, please tell us what works well

12. If you do not recognise some of the principle in your current system arrangements, please tell us what you think the barriers might be?

13. What can NHS England and NHS Improvement do to support you in making the principles a reality in your system?