Briefing **April 2021**

Our action for you on the proposals outlined in the Integration and Innovation white paper (2021)

This briefing paper for clinical commissioning groups (CCGs) sets out the influencing NHS Clinical Commissioners is undertaking on behalf of members in response to the legislative proposals in the Department of Health and Social Care's (DHSC) white paper Integration and Innovation. This briefing includes:

- a summary of the key points we heard from member CCGs in February – March 2021
- the areas we aim to influence on your behalf to support the effective transition of CCGs and safeguard their legacy.

The white paper signals the government's intentions for integrating the NHS and proposes significant changes to the way health services are commissioned and delivered. DHSC is currently drafting a bill to enact these changes, expected to be presented to parliament in May 2021, passed by mid-July and implemented in April 2022. We have heard very clearly that the legislation is intended to be enabling to support integration and not impose strict rules on local operation.

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Our approach

Many CCG leaders have already been in meetings that we have convened directly with senior NHSEI colleagues concerning the white paper, as we have wanted them to hear direct from members what the issues on the ground are. Over February and March, we held engagement webinars with CCG chairs, lay/non-executive members, accountable officers (AOs), chief financial officers (CFOs), human resources and organisational development leads (HR and OD) and chief nurses.

At each session we provided opportunities for member discussion with senior policymakers from DHSC and NHSEI. We are continuing to talk on a weekly basis with a range of senior stakeholders in both NHSEI and DHSC about the detail of the white paper and how the draft bill is progressing. Both the DHSC bill team and NHSEI colleagues have already indicated that they are open to taking on board various points that reflect member concerns and will be looking at the detail that this briefing contains to inform the draft legislation and guidance. This work is also going on in meetings with government ministers, opposition spokespeople and with MPs to help give them a good sense of the issues ahead of the bill being introduced.

Your priorities

Our engagement raised several key concerns/areas of clarification from you. In short, these are:

Employment transition: Publication of an HR framework supporting the transition to ICSs, clarification on 'board-level' definition, and letters of continuing employment.

Clinical leadership: Embedding clinical leadership on ICS NHS bodies while allowing local flexibility around their composition.

Financial allocation: Having guidance on financial allocations for place, reflecting population need and health inequalities, allowing local energy to focus on efficient use of those resources.

Transition: Allowing time and support to assume new commissioning responsibilities, ensuring capacity for change management, and effective transition of functions.

Actions we are taking for you

Our engagement highlighted that we will need to focus largely on the guidance that NHSEI/DHSC develop to support the transition of CCGs. We are fully committed to ensuring that key elements of CCG legacy are built into ICSs. Our influencing plan on your behalf is therefore framed around three types of policy levers best placed to address your concerns:

1. **Legislation** (to inform the draft bill or amendments)
2. DHSC or NHSEI **guidance**
3. Areas for **local determination** by ICSs.

What we intend to influence in 2021

Clinical leadership has been the top priority members have raised with us, stressing the fundamental importance of multidisciplinary, distributive clinical leadership to the success of ICSs. ICS NHS bodies will be accountable for key decisions and functions based on clinical advice, for example quality assurance and safeguarding, or service reconfigurations based upon a clinical case for change. Such accountability will by necessity require clinical skillsets at board level. While we agree with DHSC's aim for the bill to provide a permissive minimum legal structure with minimum prescription of detailed legal rules, we feel it is very appropriate that DHSC guarantees clinical leadership on ICS NHS bodies as part of the minimum legal structure in its health and care bill.

The best practice clinical leadership models are those that have multiple layers of multidisciplinary clinicians and professionals within a distributed leadership model, with individuals leading on specific areas of work according to their expertise and being heard at the highest levels. The nature of this clinical leadership is not just on ICS NHS bodies: equally important is the linkage to all clinicians within the system. In line with the permissive legal approach of the bill, we believe the appropriate composition of professional representation of medical, nursing, allied health professions (AHPs), lay/non-executive and other members should be addressed by a combination of national guidance and local determination. We will seek to inform guidance and local best practice through our ongoing clinical leadership work programme, which many of our members are currently engaged in.

The table on pages 5 and 6 sets out the policy positions we believe members want us to influence. Further details are covered in the appendix. Please note we are already in discussion with DHSC and NHSEI about these issues.

Our ask	Our proposed position and action		
	Legislative	**Guidance (NHSEI and/or DHSC)**	**Best practice/local determination**
Guarantee clinical leadership in the NHS ICS body	DHSC's health and care bill should include specific legal provision for "clinical leadership" at an ICS NHS body level, not just "clinical advice" as noted in the white paper, given these bodies will be accountable for clinical services.	Guidance should address the nature of clinical leadership in practice and the composition of different clinical professions (such as ensuring nursing and AHP leadership) and the wider composition of ICS bodies, also including a lay/non-executive member presence to support accountability.	We are working with members to define best practice models and key principles for effective clinical leadership within an ICS.
Clarify the role of lay and non-executive membership	N/A	Guidance should address the nature of lay/non-executive member presence to support accountability, not only at ICS NHS body and health and care partnership but also at place level.	We are working with members to define best practice models and key principles for effective lay/non-executive representation within an ICS.
Effective transfer of statutory CCG functions and roles to ICSs – avoid orphan functions	N/A	Influence NHSEI guidance and function mapping. Ensure due diligence in the transfer to ensure there are no orphan functions.	We will work with members to identify how key CCG functions should operate in a system context, such as medicines optimisation and NHS continuing healthcare.
A clear and supportive transition for CCG staff to ICSs	Ensure legislation enables the smooth transfer of staff contracts from CCGs to ICSs.	Influence the NHSEI HR Framework for the transition, ensure letters of continuing employment are issued at pace and definition of board-level positions are clarified.	We will work with members of our HR and OD Forum to define best practice.

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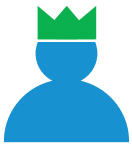
	Legislative	Guidance (NHSEI and/ or DHSC)	Best practice/local determination
A phased transfer of new commissioning responsibilities	The health and care bill should permit variable commencement of the transfer of new commissioning responsibilities to ICSs, ensuring ICSs only assume these when ready.	Reiterate phasing in the guidance especially in relation to the phased transfer of primary care and specialised commissioning functions and its resources from NHSEI.	N/A
Seek alignment to existing place-based structures (where they work well) such as health and wellbeing boards (HWBs)	N/A	N/A	Issue recommendations on best practice in relation to the evolving role of HWBs in the ICS context – based on the legacy of CCG and local government joint working (through NHSCC and the Local Government Association).
Support financial allocation at place	N/A	Influence the guidance to support financial allocation at place – focusing on population need and tackling health inequalities.	Share good practice from CCG experience to evolving ICSs re place-based budgets.
Embed independent quality assurance	N/A	Build on the current independent quality improvement oversight that is lay/non-executive member led and trusted by the public, with executive accountability at the ICS NHS body.	Work with our Nurses Forum and Lay Members Network to influence good practice principles.
Support transitional capacity	N/A	Request additional resource for CCGs/ICSs for change management during 2020/21.	Work with CCG and ICS leaders to share best practice in transitioning.

Procurement is excluded from this document: our views on NHSEIs proposals for a new Provider Selection Regime, which will be enabled through legislation, will be set out separately in the NHS Confederation's response to NHSEI's consultation on this issue.

Other areas we will be influencing via the NHS Confederation/ICS Network

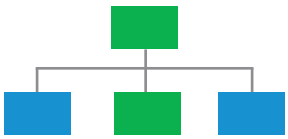
While the issues outlined above are particular concerns for CCGs, members shared feedback with us on a wider range of issues which also affect other parts of the NHS. On these issues, we will support other networks within the NHS Confederation to seek to inform and influence policy decisions. These are covered in further details in the NHS Confederation's report Legislating on the Future of Health and Care in England.

Areas we will collaborate on with the wider NHS Confederation:



Power of direction: Providing clarity over the extent of the Secretary of State's powers of directions and ensuring appropriate checks and balances, including clinical opinion.

Areas we will work on with the ICS Network:



ICS leadership/governance: Ensuring a suitable timeline for appointments of statutory ICS chairs, achieving the appropriate mix of expertise on NHS ICS bodies, and clarifying intra-ICS relationships (such as NHS bodies, health and care partnerships, and health and wellbeing boards).

Regulation: Clarifying the Care Quality Commission's relationship with ICSs, ensuring a systems approach while preserving CCGs' legacy as quality assurance partners.

Place: Ensuring strong provisions for place-level arrangements.

We would welcome further feedback and input from members on the overview and positions set out in this document. To share your feedback, please contact office.nhscc@nhsconfed.org

Appendix: Overview of key issues

Issues marked * are priority areas NHSCC will lead on as part of the NHS Confederation.

Issue: Clinical leadership*

Action: Legislation and guidance

Position: Guarantee clinical representation on ICS bodies in legislation

Clinical leadership has been the top priority members have raised with us, stressing the fundamental importance of multidisciplinary, distributive clinical leadership to the success of ICSs. ICS NHS bodies will be accountable for key decisions and functions based on clinical advice, for example quality assurance and safeguarding, or service configurations based upon a clinical case for change. Such accountability will by necessity require clinical skillsets at board level. While we agree with DHSC's aim for the bill to provide a permissive minimum legal structure with minimum prescription of detailed legal rules, we feel it is very appropriate that DHSC guarantees clinical leadership on ICS NHS bodies as part of the minimum legal structure in its health and care bill.

The best practice clinical leadership models are those that have multiple layers of multidisciplinary clinicians and professionals within a distributed leadership model, with individuals leading on specific areas of work according to their expertise and being heard at the highest levels. The nature of this clinical leadership is not just on ICS NHS bodies: equally important is the linkage to all clinicians within the system. In line with the permissive legal approach of the bill, we believe the appropriate composition of professional representation of medical, nursing, AHP, lay/non-executive members and other members should be addressed by a combination of national guidance and local determination. We will seek to inform guidance and local best practice through our ongoing clinical leadership work programme, which many of our members are currently engaged in.

Issue: Function transfer*

Action: Legislation

Position: Ensure effective transfer of functions through mapping

It is important to ensure no important functions are orphaned during the transition from CCGs to ICS, including CCGs' non-commissioning functions such as quality assurance and risk assessment. We are collaborating with NHSEI to conduct due diligence and map transfers currently held by CCGs and ensure they are appropriately allocated in the new healthcare system and to inform the bill.

Issue: **New commissioning responsibilities***

Action: **Legislation**

Position: **The health and care bill should permit variable commencement of the transfer of new commissioning responsibilities to ICSs**

We welcome the transfer of responsibility for commissioning primary care and some public health and specialised services to ICSs, to enable better integration of care at a system level. We also welcome the ability for commissioning of some such services to be shared across ICSs, as may be locally appropriate corresponding to population sizes. This approach will enable local decision-making on primary care provision and enhance ICSs' capability to address health inequalities and cater to population health needs.

Members noted that commissioning such services will require new skill sets and expertise within ICSs to ensure the continuity of safe and effective care; expertise which it will take time to put in place, beyond the April 2022 deadline for implementing the bill. DHSC should ensure the bill permits variable commencement of its provisions to transfer new commissioning powers, ensuring the appropriate expertise is in place before responsibility is transferred. Legislation should permit delegation of primary care and public health services within ICSs (to place and/or neighbourhood level as deemed appropriate locally). NHSEI should engage CCG medicines leads to review the list of designated specialised services.

Additionally, the bill should make provision for negotiation and contractual administration of some services – such as primary dental care – to be delivered at a national level to avoid duplication and reduce administrative costs.

Issue: **HR framework***

Action: **Guidance**

Position: **Publish HR framework and issue letters of continuing employment as soon as possible**

NHS staff are the bedrock of the health service, including current CCG staff whose expertise will be vital to the success of ICSs. We welcome NHSEI's employment guarantee for CCG staff below board level. Members noted that any employment uncertainty risks losing talented staff. NHSEI should issue letters of continuing employment and publish its HR framework, providing a clear definition of 'below board level' and setting out a roadmap for staff to move from CCGs to ICSs, as soon as possible, and continue to engage CCG HR and OD leads during the transition. Additionally, legislation must enable the smooth transfer of contracts from CCGs to ICSs.

While the balance of leadership requirements for ICSs will differ from CCGs, CCGs contain a wealth of talented leaders (not covered by NHSEI's 'below board level' guarantee of continuing employment) who are well placed to take on place level and system level leadership positions within ICSs. Existing CCG leaders should be a 'first port of call' for ICS chairs assembling their leadership teams at place and system level. Guidance should encourage ICSs to draw on some of the experienced CCG leaders to maintain the organisation memory and positive legacy of CCGs, continuing to support local accountability.

Issue: **Financial allocations***

Action: **Guidance**

Position: **Provide population-need-based guidance to inform ICS financial allocations to place level**

Integration of commissioning budgets at a system level enables greater local flexibility to use available resources most effectively. Members noted that ICSs' allocation of resources to place level should be informed by population health needs. NHSEI should issue guidance to assist ICSs in allocating appropriate funding to place level, helping to focus local energy on how best to collaboratively deploy available resources to meet patients' care needs and improve outcomes. NHSEI should continue to engage CCG CFOs on this issue.

Issue: **Quality assurance***

Action: **Guidance**

Position: **Build on the current independent quality improvement oversight that is lay/non-executive member led and trusted by the public, with executive accountability at the ICS NHS body**

CCGs currently perform an essential quality assurance function, monitoring the standards of care delivered by providers they commission – a distinct but complementary role to that played by the CQC. While the inclusion of providers on ICS bodies is an essential component of collaborative care, members noted this risks creating a conflict of interest on quality assurance monitoring. ICSs should establish independent quality assurance boards, led by a lay/non-executive member and including an executive director of quality assurance (ideally a qualified nurse), to avoid such a conflict. Several ICSs are already employing this model, a best practice approach which should be replicated elsewhere. NHSEI should continue to engage with CCG chief nurses during the transition to use their organisational memory and protect quality assurance.

Issue: **Transitionary capacity***

Action: **Finance**

Position: **Provide additional resource for change management**

Members broadly support the direction of travel set out in the white paper to enable collaboration and better patient care. As we have learnt from past periods of change in the NHS, change management always consumes resource. CCG commissioners will play a key role in delivering this transition. At an unprecedented time when NHS resources are stretched to address the COVID-19 pandemic and clearing the backlog of elective care, members note that additional capacity is needed to support change management during the transition to ICSs. DHSC should liaise with HM Treasury to provide additional financial support to ensure the necessary period of transition to ICSs does not divert resources from patient care.

Issue: Boundaries

Action: Legislation and local determination

Position: Allow flexibility and local determination in legislation

There are heated discussions ongoing around ICS boundaries. The white paper states that ICS boundaries will 'frequently' be coterminous with local authority boundaries, suggesting a degree of flexibility. NHSEI's implementation guidance to support NHSEI's planning guidance for 2021/22 states that 'ICS boundaries will align with upper-tier local authority boundaries by April 2022, unless otherwise agreed by exception.' While this report does not plan to go into the detail of this issue, it should be noted that if the bill does include a requirement for ICS and county council boundaries to be coterminous, this requirement will have implications for timescales – threatening to set back significantly the progress of affected systems.

The government must think carefully about proposed timescales set out in the bill. In light of the concerns raised above, it should take timely action to resolve ongoing issues that threaten implementation timescales, including around appointments and boundaries, if the April 2022 deadline is to be kept. Additional support may will be required for some ICSs – for example those impacted by boundary change – to ensure that no ICS is disadvantaged by delays to these decisions.

Issue: Regulation

Action: Legislation

Position: Accommodate ICSs as quality assurance partners

The CQC has proposed a new strategy which would empower it to regulate care quality at a system level, continuing routinely the system reports it currently requires special permission from the Secretary of State to deliver. The Secretary of State has confirmed his intention for the CQC to provide "Ofsted-style ratings" of ICSs' performance, however the exact nature of these ratings and the extent to which they are similar to provider ratings is not yet clear.

Members have told us that the CQC's system reports have been helpful for supporting improvement, and an expanded remit for the CQC to assess care across patient pathways would be beneficial. The future regulatory relationship between the CQC and ICSs should account for CCGs' (and in future ICSs') quality assurance function (as noted above), acknowledging ICSs as partners.

Issue: **Power of direction**

Action: **Legislation**

Position: **Ensure appropriate checks and balances**

The white paper proposed strengthened powers of direction for the Secretary of State over NHSEI. Members recognise the benefits this will bring to allowing a faster resolution of local service reconfiguration disputes and welcome the restrictions on intervention in local and clinical decision-making. Where the Secretary of State is exercising this new power to rule on service reconfiguration decisions, there should be a requirement for him to consider the clinical case for change. The bill should ensure effective checks and balances on this power to preserve the positive legacy of operational independence for the NHS over most of the last decade.

Issue: **Governance and accountability**

Action: **Guidance (Model ICS Constitution)**

Position: **Advise on board composition and intra-ICS relationships**

Members understand the rationale for having dual bodies and partnerships and want to ensure they function effectively and do not divide ICSs or duplicate activity. NHSEI should issue guidance, in the form of an ICS Model Constitution, to inform the composition of and the relationship between new ICS NHS bodies and ICS health and care partnerships. This should include clinical leadership and a patient voice to enhance accountability and ensure balanced representation of local healthcare leaders (also see position on clinical leadership, above) and lay/non-executive representation. It should also advise on candidates from wider sectors (such as housing or justice) who may be beneficial to join health and care partnerships to support population health management. Such guidance should encourage lay/non-executive member and patient voice to be embedded in ICS governance.

Issue: **Structures and health and wellbeing boards**

Action: **Local determination**

Position: **Issue recommendations on best practice to inform flexible local thinking**

While national guidance provides a vision for optimal working practice and a model for local leads to take a lead from, different systems should retain flexibility to determine the most appropriate relationships between various components of ICSs (NHS bodies, health and care partnerships, health and wellbeing boards and other place-based arrangements), but national recommendations on best practice/model operations would help to inform local thinking.

Issue: Place

Action: Local determination

Position: Identify models for strengthening place-level arrangements

We understand that place will not be a legally recognised unit, with ICSs organising place-based arrangements internally in each locality as they deem appropriate. Members stressed the importance of strong leadership and working arrangements at a place level. NHSEI should work with our members and the NHS Confederation's ICS Network to identify models for strengthening place-level arrangements and enabling delegation of considerable funds and responsibilities to place.

Issue: ICS leadership appointments

Action: Recruitment

Position: Confirm ICS NHS body chair appointments as soon as possible so they are in place in by the end of September 2021

As ICSs move to statutory bodies, we understand that a formal recruitment exercise is required for ICS chairs and not all current chairs will necessarily take on these roles. In some areas, chairs will lead both their ICS NHS body and health and care partnership; in others, the role may be divided according to local preference. Members stressed the need for continuity of leadership during the period of change management and the initial years of ICSs operating in statutory form. NHSEI should appoint ICS chairs as soon as possible so they can be in place by September 2021 and appoint their leadership teams.

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