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Clinical and Care Professional Leadership Guidance

Skills for Health and The Cynefin Company

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Acknowledgements

The authors of this report would like to thank the focus groups, interviewees, and SenseMaker participants for sharing their views and experience of implementing the NHS England guidance on Effective Clinical and Care Professional Leadership, as part of their organisations' transition into Integrated Care Systems.

We are very grateful for their contributions, both in emerging practices and ideas uncovered through participation in our data collection, and through the submission of detailed case studies.

It is hoped that this report will inform progress and contribute to a culture of shared learning across Integrated Care Systems, and the development of effective clinical and care professional leadership.

Executive summary

In this learning report, we will share a collection of stories, case studies and perspectives on the application and implementation of the Clinical and Care Professional Leadership guidance (hereafter referred to as CCPL). During the course of this research we have been able to listen to and observe the process and experiences of colleagues across all seven regions and in multiple Integrated Care Systems (hereafter referred to as ICSs) as they build the local frameworks and development plans that will form the foundation of system approaches to clinical and care professional leadership.

The report, of course, captures a moment in time; one that is characterised by significant transformational change and challenge, with competing demands and expectations placed on all of the NHS – the enduring impact of the COVID-19 pandemic, the formal transition to statutory Integrated Care Boards (ICBs), and the operational, workforce and strategic pressures associated with meeting the ambitions of the NHS Long Term Plan within this context.

Therefore, we ask that what follows be taken in context, and the ideas, experiences, and ambitions of colleagues and systems reflected in the content considered as part of a collective journey towards distributed, multi-professional and inclusive leadership.

In order to ground this report in the lived experiences of colleagues undertaking the implementation of the CCPL guidance, we have structured the report into three chapters, each of which is led by participant contributions.

Chapter 1 – What we heard

In this chapter, we present a synthesis of our findings drawn from all of our data-gathering activity, categorised by each of the five principles for ICSs. In particular, among the key themes are references to the following:

- Key themes
- Challenges and opportunities
- Case studies
- Lessons learned in the form of top tips, in which we describe the key learnings that we have heard, which reflects the experiences of participants in the design and development of frameworks and plans to date.

This chapter includes contributions from a rich mix of systems from multiple ICSs across all seven regions in England, and across a diverse range of activities, reflecting a wide scope of progress.

Chapter 2 – Case studies

In order to make sense of the patterns emerging from our learning report, and to reflect on the consideration being given to complex issues and the significance attributed to progress and development in this area, we present case studies that reflect our interpretation of the diversity of progress, focusing on three areas:

Emerging ICB frameworks where significant progress has been made in system-wide engagement and design, and a model for governance has been proposed.	Frameworks in design – approaches to method where significant local and system-wide design principles have been applied, but the framework is still under development.	Principles in practice – examples of what 'good looks like' when the principles are used to guide and inform practice, and what the opportunities for change are when they are rooted in strategy, design and delivery.

In some cases, the examples will speak to all three categories of development, and in others we will seek to elevate the practices that are informing Clinical and Care Professional Leadership (CCPL) framework design, especially where we have found that these reflect the CCPL guidance principles and would encourage the acknowledgement of this in plans.

In general, we have considered this research to be profoundly positive, demonstrating the engagement which informed the guidance: that is, the principle of building upon the foundations of fully inclusive multi-professional clinical and care professional leadership, as referenced in the quote below.

> *"When you're coming together in a new group, do you spend your time thinking about really big issues such as strategy, or do you spend your time thinking about very small issues that are clearly defined? Do you address those small issues and hope that whilst dealing with them, the details of the bigger issues will be revealed?*
>
> *Do we tackle large issues like how to build better leadership relationships – or smaller, more defined issues such as how to improve outcomes for people with type 2 diabetes in the local Asian population? We haven't come to a conclusion on this yet, but I think we're converging on getting down and doing things together, addressing small issues together, and getting activity started."*

Chapter 3 – Conclusions, and looking ahead

This chapter summarises our final reflections. There is no summary conclusion attached to this report, as the key themes and lessons learned are explored throughout the first two chapters, based on the feedback, in a way that captures the deep complexity of this work and the patterns that are emerging from the data gathered.

Introduction

The clinical and care professional leadership guidance was published last autumn following engagement with over 2,000 clinical and care professionals from across the country. The engagement exercise sought to understand what good clinical and care multi-professional leadership would look like in an Integrated Care Systems (ICS) context, and the key challenges to making this happen.

The principles described within the guidance were designed to address those challenges and support the development of distributed clinical and care professional leadership across ICSs, as part of a set of resources developed by NHS England and NHS Improvement to guide systems through to the statutory establishment of Integrated Care Partnerships (ICPs).

Skills for Health have engaged with ICSs as they work through what the CCPL guidance means to them, and the opportunity it presents to reconsider leadership in the contemporary context of health and care. We have compiled a report that we hope captures the key points of learning, using the experiences of practitioners involved in developing and delivering local plans to anchor the report in reality, and encourage further and ongoing development.

"Our ICS is utilising population health management approaches to help us to understand our current health and care needs, to predict our future needs, and to design more joined-up and sustainable health and care services, which help us to address the current health inequalities across our system.

We are working in partnership across the NHS and with other public services, including councils, the public, schools, the voluntary sector, housing associations, social services, police and fire services."

The guidance does not describe the full breadth of professional leadership arrangements across the ICS, or the role of all constituent partners; it focuses on how the NHS should contribute to effective clinical and care professional leadership, working equally with local government, social care and other partners.

The report takes into consideration the following three key points:

1. It acknowledges the important role of multi-agency, multi-professional and multidisciplinary working in seeking to address the complex, contemporary environment of health and care.
2. It provides a stimulus for systems to explore, challenge and in some cases reimagine the role of leadership, and the structures that influence its practice.
3. Highlighting the opportunity presented through engaging with staff and patient communities that is focused on equity and inclusion throughout the system.

When writing this report, we have sought to ensure that the content is guided by the participants, and the way in which we have collected the data represents our commitment to sharing the stories, experiences and voices of those involved in the work, as we heard them. We hope that the report accurately demonstrates the many examples of outstanding, innovative leadership across all systems, and the range of approaches being used to design a local framework that can form the backbone of a future-focused model of clinical and care professional leadership.

With that in mind, throughout our experience of collecting this data three things have remained clear, consistent and worthy of elevating to the front of this document:

This is complex work, with no standard model of practice.

The guidance has been written in a way that is designed to recognise individuality in the systems and to be permissive, describing what 'good' looks and feels like, rather than how systems are expected to achieve it. Although there is no shortage of thought pieces, perspectives, and guiding documents available to support colleagues in this endeavour, ultimately there is no guarantee that any advice will be applicable to, or reflect, the unique changing and interdependent nature of the communities, places and neighbourhoods that make up each ICS. What we have heard over and over again is that we must recognise the commitment required to invest in relationships across neighbourhoods, places and systems to respond to this unique opportunity for change.

Not all of the stories, experiences and reflections on progress are positive, and much of the work required is rooted in the conflicting tensions and complex relationships that are inherent to the delivery of health and care.

We have heard clearly that this work will not be undone, improved or fixed without a long-term and strategic approach to the application of the guiding principles. Whilst the system emerges and evolves following transition, the evidence of impact with regard to the principles in practice is limited. However, the cases that we have captured demonstrate powerful arguments for the potential of local plans to enact change, and to significantly counter traditional ways of working. This offers a valuable map for colleagues as they put the principles into practice.

The complexity of the work is consistently matched by the investment in time, energy and commitment of those undertaking the development of a clinical and care professional leadership plan.

This has been seen in the way that participants seek to explore genuine transformation, and in the way they balance pragmatic, practical evolution with the scale of hope, ambition and imagination required to match the expectations of the guidance. In short, we have been deeply impressed by the scope of work and the care taken with the development of the local plans and framework.

In the best examples and the most powerful stories we share, clinical and care professional leadership in ICSs is being pursued as a set of integrated practices that if considered in relation to many contributing and interdependent factors, with partnerships, relationships and networks at their heart. Furthermore, we heard clearly from participants is that any ICS is to genuinely use the principles as a guide towards a system that thrives, that is inclusive and representative, and that invests in strategic, integrated healthcare must be taken to understand the complex challenges associated with effective clinical and care professional leadership. This requires committing resources and significant energy to understanding what it takes to shift the dominant paradigm towards one that is local and place-based.

It is our hope that by taking these three themes into consideration, the content of this report reflects more than a collection of individual cases. Instead, it adds to the growing sense of community and shared purpose that we have experienced. Whilst our experience of gathering evidence has demonstrated a broad spectrum of readiness among healthcare leaders, this is not unexpected, and should not deter from the significant, deeply important and practical development that we have been able to represent here.

It has been a privilege to spend time with colleagues to listen to the scale of ambition, insight and creativity that has powered this piece of work, and we would like to express our gratitude to all participants for giving their time, effort and energy.

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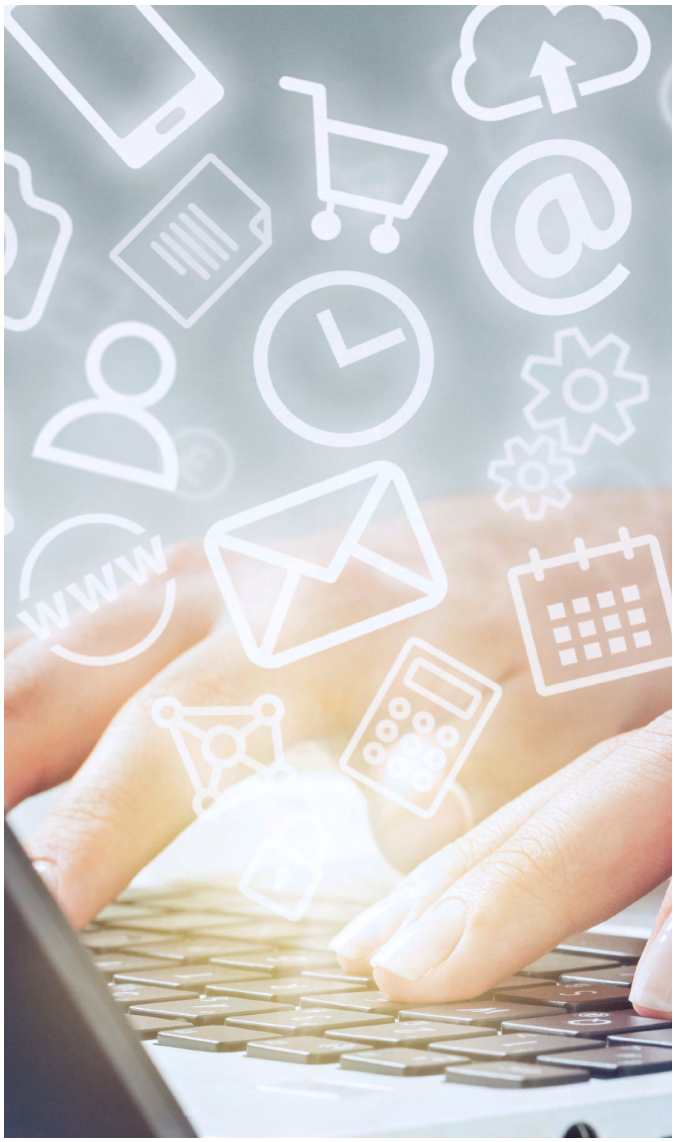
Background

Skills for Health, in partnership with The Cynefin Company, have undertaken research and engagement activities across systems to establish what the Clinical and Care Professional Leadership (CCPL) guidance entails for their transitioning into Integrated Care Boards (ICBs) and how systems are embedding the guidance's five principles. The main purpose of the research is to highlight and share learning across all 42 ICSs across England, although there is considerable content applicable directly to ICBs, and we hope for all clinical and care professionals.

The shared learning draws from 18 case studies from across all regions in England, 20 SenseMaker stories shared, and over 50 sessions (including interviews, regional working groups, Communities of Practice, meetings, follow-up case studies, etc.) attended throughout March 2022, with over 100 clinical and care professional leaders (including two national Communities of Practice) engaged in these primary research methods.

Mixed focus groups were conducted in partnership with The Cynefin Company throughout March 2022. A total of 24 participants attended one of the six focus group sessions offered by Skills for Health and The Cynefin Company.

For more information about our methodology, please see the methods section in the Appendix.



The scope of the research focused on:

Key themes emerging from conversations, experiences and practices being delivered across systems

Challenges, barriers and opportunities re the development of local plans

Key learnings – considered as an evolving process as systems continue to transition and change

Case studies – captured under three categories, but all distinctive to the context of place

The key document guiding the development of this shared learning report is:

- NHS (September 2021) *Building strong integrated care systems everywhere. ICS implementation guidance on effective clinical and care professional leadership:*

Other guidance documentation that has supported the development of this report include:

- NHS (June 2019) *Designing integrated care systems (ICSs) in England. An overview on the arrangements needed to build strong health and care systems across the country*
- NHS Confederation (September 2021) *Clinical and care professional leadership in integrated care systems: A thematic report from engagement events in March 2021 and mini literature review.*
- NHS (June 2021) *Integrated Care Systems Design Framework*
- NHS and Local Government Association (June 2021) *Thriving places: Guidance on the development of place-based partnerships as part of statutory integrated care systems*
- National Quality Board (April 2021) *Position Statement on Quality in Integrated Care Systems*
- National Quality Board (April 2021) *A shared commitment to quality for those working in health and care systems*
- Department of Health and Social Care (March 2022) *Integrated care partnership* (ICP): *engagement summary*

Chapter 1 - What we heard

1. Introduction: an opportunity to be realised

In this chapter, we present the key themes and content of our interactions with participants, synthesising data to capture learning and experiences in this period.

We have listened to the ideas, questions and themes that are steering the dialogue in our engagement with systems; take part in conversations in focus groups, working groups and Communities of Practice; and reflect on a diverse pool of case studies. From these interactions, a number of opportunities have been highlighted.

Firstly, the guidance is seen as an opportunity to stimulate a culture of learning that has not always been present within and across systems of health and care. Secondly, the guidance is seen as an opportunity to elevate listening, sharing, and relationship-building with others, learning from their processes and engaging with alternative ways of viewing the system in order to do things differently. Thirdly, the guidance is seen as an opportunity to reconsider and reimagine what leadership looks like when it is centred on places and citizens, when it is informed by the principles of systems and complexity, and when it is inclusive and reflective of the community it serves.

> *"We are going to focus on team building and education on system leadership, and what it means to all across the board."*

Finally, the way that the guidance acts to inform, but not dictate, the practice of clinical and care professional leadership is an opportunity for far greater system creativity: by providing a canvas for experimentation, with a focus on delivering better, more integrated patient care through leadership and leadership development, systems can map their own journey and respond to their own, place-led and community-powered environment.

> *"The application of clinical and care professional leadership allowed us to integrate the profession with most patient contact into primary care, saving GP time and appointments and reaching hard-to-reach patients."*

> *"There is an opportunity [with clinical and care professional leadership] to bring multi-agency progressions to deliver better care."*

1.1 Key themes and lessons – clinical and care professional leadership at the heart of ICSs

Over the course of three months, we participated in a rich process of learning, observing multiple groups exploring the guiding principles in practice.

Participants from ICSs across the country were encouraged to reflect on the ways in which they were engaging with the guidance, and to consider and share the approaches they were taking to the design and implementation of their local plans.

This experience has been translated into a collection of lessons learned that can be shared and incorporated by other organisations. These have been grouped into the CCPL's five guiding principles, to facilitate understanding of how these lessons and principles interconnect.

The findings draw from discussions surrounding the case studies, focus groups, interviews, meetings and working groups, as well as the data collected through SenseMaker and associated focus groups.

The sections below begin by reflecting on the key themes, challenges and opportunities, and lessons learned – an evolving process – in the form of top tips organised around each principle of the guidance. In this section we start to reflect on the key issues we have heard, and suggest recommendations the areas, issues and themes that are emerging as critical issues in the development and implementation of the clinical and care professional leadership guidance.

Principle 1: Ensure that the full range of clinical and professional leaders from diverse backgrounds are integrated into system decision-making at all levels, supporting this with a flow of communications and opportunities for dialogue.

Key themes

All organisations and stakeholders agreed that having the right representation of clinical and care professionals at every level in the ICS, as well as in governance structures, networks and working groups, was key for their transition period and for moving forward. A link between the clinical and care professional groups and chief executives (director of nursing, medical director, CEO, etc.) was regarded as crucial to ensure engagement across the system, as was clear messaging delivered across professional forums.

> *"It makes sense for clinicians and the community to work together to make change... these people are key to improving health and wellbeing in the community."*

Equity of access for all clinical and care professional groups also needs to ensure engagement from the Voluntary, Community and Social Enterprise (VCSE) sector, local authorities, professional membership organisations, citizens, patients and carers. A voluntary sector alliance was highlighted as a positive move to support and maintain engagement, ensuring the VCSE sector feels and recognises that it is invited to be part of the system.

> *"Ensure all professions are equally represented in decision-making for our system moving forwards (not just represented through other professions, e.g. medics/nursing)."*

It was essential to establish a governance structure from the beginning, at both system and place level, as this provides the strategic steer needed, whilst also ensuring that the ICS vision is owned by senior clinical and professional leaders across the system and cascaded widely. A memorandum of understanding to help clarify priorities at each ICS level (specifically at neighbourhood and place) was encouraged, as well as having a shared understanding and language of different high-level concepts.

> *"The main reason we should try to change 'in the way that is imposed' upon us. There was a sense that mutually agreeing this is useful. This could act to create the case for change."*

Decision-making is emerging through small pockets of multidisciplinary discussion and action

Engaging with wider professional groups at an early stage of the transition was important to gain their support and develop networks within the systems. Open and regular communication is necessary with a diverse and wide range of professional groups to encourage collaboration across the system and collect feedback that helps shape future agendas.

> *"We are having regular Professional and Clinical Leadership Assembly meetings where we have useful, productive discussion and agree actions to take."*

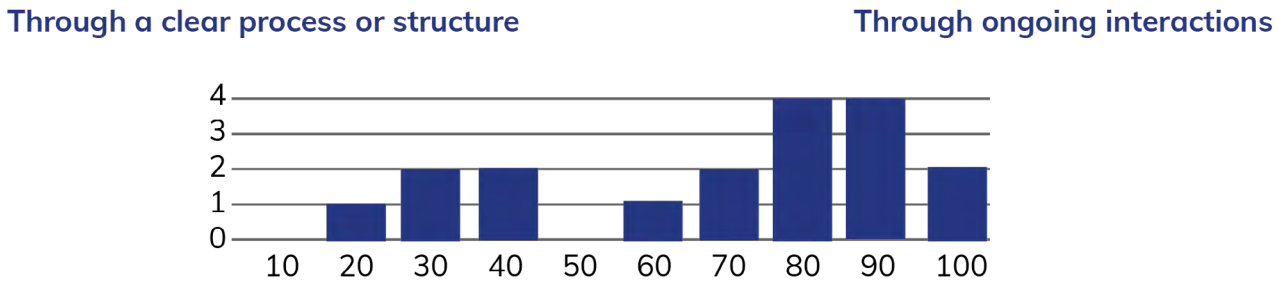
The SenseMaker findings suggest that current energy is focused on dialogue and opening communication styles. Positive outcomes are being achieved by small multidisciplinary groups that come together with the potential to do things differently and learn from one another. Some examples shared were building on existing networks:

> *"Utilising clinicians to identify other leads to contribute to the project."*

Furthermore, having regular meetings and open discussions with a diverse group helps to build trust:

> *"A lot of trust developed that [ensures all] professionals will be treated equally."*

We asked participants to consider how decisions were made. We can see from the figure below that decisions are being made more through ongoing interactions. It would be interesting to see if this pattern shifts over time towards the middle/left side of the scale, as new ways of engaging with one another and making decisions in collective ways start to become more commonplace.



Challenges and opportunities

It is clear that implementation of the guidance is still very much in its infancy among groups that participated, although some are further ahead in terms of governance arrangements:

> *'Senate' or 'cabinet' models have been celebrated: "Portfolio originally had three legs – governance and engagement, leadership and cultural change, and transformation and strategy...we mapped the principles to this structure, and it knitted together quite nicely."*

One of the key challenges highlighted was the large size of groups (e.g., clinical senates), with one person stating there were 44 people in their clinical and professionals' group:

> *"The group becomes massive and unwieldy quite quickly."*

As a result, several organisations implemented clinical forums with subject areas as a way of moving forward. Cross-county, multi-professional working groups sponsored by the senate also enabled the work to be focused and move at pace.

Challenges and risks: timescale to evolve cultural transformation

Several participants voiced a fear that, despite the rhetoric around system change and greater parity of esteem, governance structures continue to reflect more traditional models that are doctor-led.

> *"We have found phrases like 'engaged with' and 'represented from' creeping in...tokenism that has gone on before."*

As new configurations of distributed decision-making emerge, there is a sense that there are lessons to be learned from the NHS's response to COVID-19, which forced clinical leads to make changes to existing ways of working to keep both service users and the workforce safe. Now that this situation is shifting, the parameters of decision-making are seen by some to be becoming more enclosed, creating a reversion to 'past behaviours' and feelings of exclusion as individuals become more 'inwards facing' to 'survive'. One SenseMaker story mentioned the undoing of hard work in the design of a model of CCPL for ICS. As pressures pile up, this is compounded by a burnt-out workforce and 'restructuring fatigue' alongside increased redeployment into roles that individuals might not feel adequately prepared for.

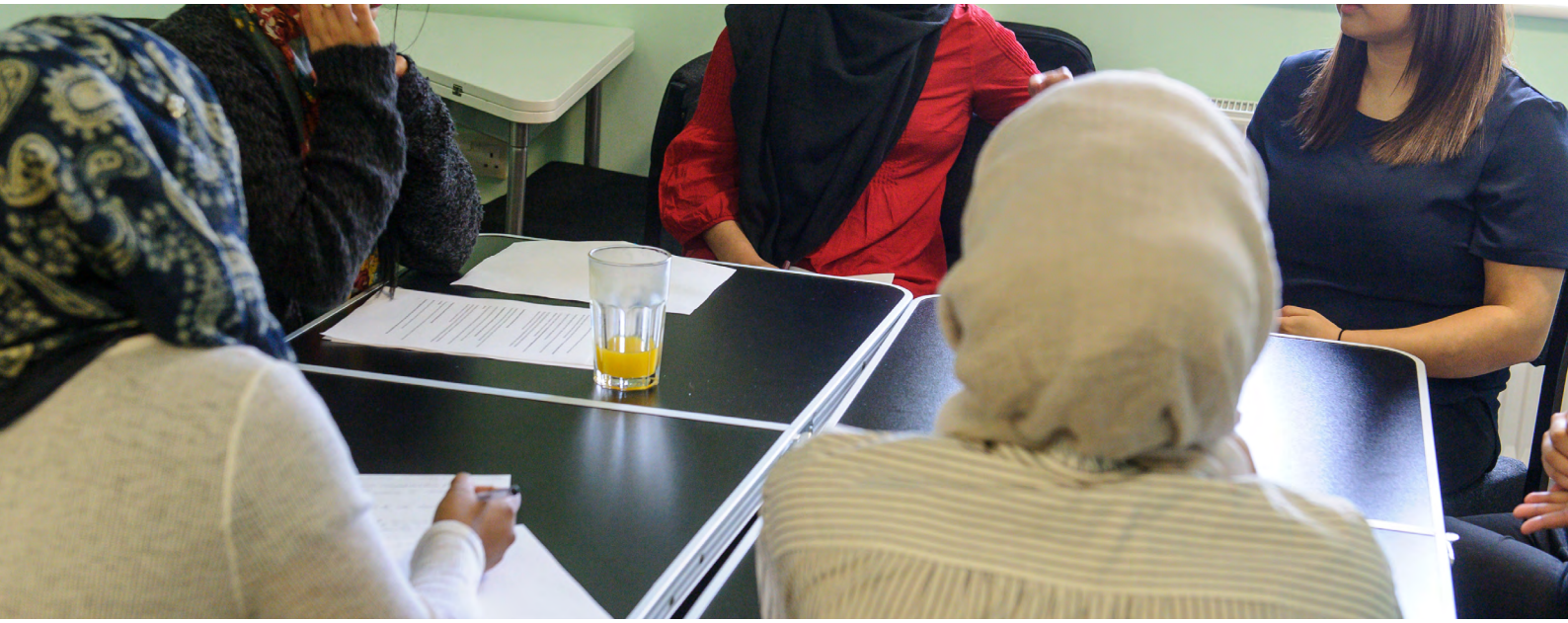
It was clear from most of our findings that people are concerned about how to extend the learnings out to everyone to provide place-based care. One SenseMaker participant, for example, reflected that a barrier to the guidance implementation might be in the relationships between system and place, and the requirement to effectively resource system working; there is a strong preference for clinical and care leadership to be anchored in place, but with the ability and opportunity to take a system lens. In order to facilitate this, resourcing and time must be committed.

> *"A barrier will be how to release clinical leaders for system working."*

Case studies

Several case studies highlighted the importance of Principle 1 being embedded within their systems, such as Frimley Academy, which created a multi-layered leadership alliance and leadership conference framework.

> *"The Academy aims to do this by creating a multi-layered leadership alliance and leadership conference framework which enlists the lived experiences, expertise and insights of an extensive array of stakeholders spanning the wider Frimley Academy leadership network community."*



Improved relationships and multi-professional collaboration also contribute towards improvement, as reflected by Bath and North East Somerset, Swindon and Wiltshire – System Leadership Academy.

> *"Now the Acute Trust have twice-weekly huddles attended by 10–15 staff members including GPs, consultants, nurses, healthcare assistants, support teams and managerial colleagues. These are well facilitated, and all staff contribute to improvement ideas."*

"The Staffordshire and Stoke on Trent Health and Care senate (SS H&CS) is multidisciplinary and extends across health and social care, comprising senior doctors and nurses as well as representatives from social care. Primary and secondary care clinicians are involved, as well as representatives of local authorities. The SS H&CS is supported by three Health and Care Assemblies (H&CAs) affiliated to the SS H&CS and aligned with the three Place-Based Partnerships (PBPs). The H&CA will provide a wide group of health and care professionals to support transformation delivery at PBP level."

Top tips

Determining governance structures and group sizes is important to continue building up the momentum from stakeholders' engagement and ensure the right representation of professional groups.

Importance of equity of access for all clinical and care professional groups, ensuring the Voluntary, Community and Social Enterprise (VCSE) sector, local authorities, professional membership organisations, citizens, patients and carers and other partners remain engaged and represented.

Set goals, agree behaviours and pathways and maintain focus in the overarching four aims of ICS: improving population health outcomes, tackling inequalities in outcomes (including experience and access), enhancing productivity and value for money, and helping the NHS support broader social and economic development.

In order to engage different professional groups, it is important to ensure there is a link between the care and clinical professional group and chief executives (director of nursing, medical director, chief executive officer, etc.) ensuring engagement across the system. It's also important to have clear messaging on professional forums.

It is key to engage with wider professionals at an early stage to gain feedback and support for the framework, and to model and develop the network.

Learn from how decisions were adapted during the earlier stages of the COVID-19 pandemic at a clinical leadership level and in the present moment, as systems pressures may prevent the guidance moving forward.

Develop a memorandum of understanding (MOU) to help clarify what will be prioritised at each level.

Consider having a voluntary sector alliance.

Ensure effective communication via regular meetings and open discussions with a diverse group to encourage opportunities for collaborative action, helping to build trust and visibility over time.

Ensure that feedback is collected from networks, working groups and programme participants (e.g. via a survey, verbally, informal networks, etc.) to help shape future agendas and share learning.

Interrogate how different individuals/ professions make sense of high-level concepts such as distributed leadership, to help create a shared language and frame for action.

Keep the bigger picture in mind and do not focus solely on short-term challenges.

Principle 2: Nurture a culture that systematically embraces shared learning, supporting clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities.

Key themes

As the title of this chapter suggests, learning is an evolving process as each ICS is established.

> *"All staff are working together as a system to deliver the right answer."*

Investment in relationship building, including fostering relationships with key team members and offering an open, trusted and positive environment are considered critical for success. These aspects help to create a culture of trust (e.g., open-door policy), respect and shared learning via formal and informal networks, framed by a co-developed shared vision that can co-deliver solutions within realistic time- frames. This also offers an opportunity for members to have a voice, express their concerns and share lessons learned.

> *"We need to encourage a system where all professionals feel they have a home."*

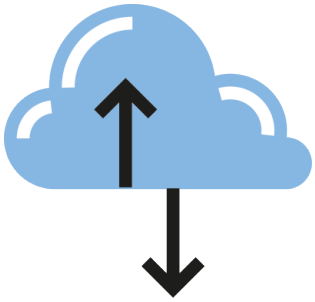
> *"Bringing primary care closer together: we have created a Primary Care Providers Leadership Forum. This includes GPs, and pharmacists, dentists and optometrists from the community. Through this forum I can already see the huge value in bringing professionals together across the system. We need to ensure that forums such as this are then connected to other clinical and care professionals within our system, and our workshop approach in Cheshire and Merseyside, used alongside an online crowdsourcing platform, is enabling this. We have rich conversations taking place as we look to develop our framework."*

The benefits of elevating place-based dialogue were seen to "proactively diversify [...] our senior clinical and professional leadership" in order to develop the governance to better support the system, as opposed to replicating existing relationships and power dynamics. There are examples in the SenseMaker findings of better information across the whole system, as the following quotations show:

> *"Using place-based teams to have local discussions that then feed into system plans."*

> *"Applying to a clinical group based on a place-based diagnostic."*

Better information-sharing was also promoted by the use of software and digital platforms (e.g., the use of 'Idea Drop' by Birmingham and Solihull Mental Health NHS Foundation Trust and Cheshire and Merseyside) to encourage shared learning and engagement in decision-making. This has been highlighted as an opportunity to elevate and align practices that may be influential in enhancing health and care outcomes, as referenced below.



> *"It is helpful to have a knowledge hub of all the examples so that people can draw upon them and learn from them."*

We have also heard clearly from participants that, alongside the power demonstrated through informal and emergent sharing of knowledge, system-led and facilitated activities have been deeply effective in promoting shared learning opportunities and encouraging collaboration. Ensuring that the CCPL guiding principles were embedded into each workstream, community, place and overall patient care has been identified as integral for system development, as well as promoting good connectivity between existing relevant workstreams across the system.

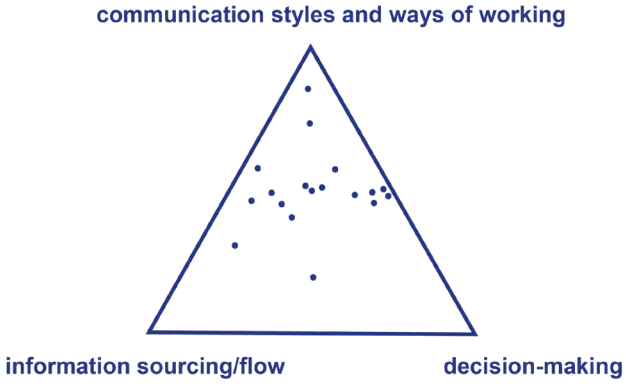
Utilising available formal and informal networks, as well as forums and events, was essential for maximising the system's impact in relation to collaboration and shared learning.

> *"The facilitation team have been fab in supporting this."*

Challenges and opportunities

As systems were currently in transition, it was expected that changes would continue in parallel with the learning process, which continues to evolve. The five principles in the guidance have been consistently supported by participants, with the main challenge being how to implement these principles in practice. Co-creating procedures, such as standard operating procedures (SOPs) and memorandums of understanding (MOUs), were used as mechanisms to develop a shared Integrated Care Board (ICB) vision and apply the principles in practice.

The approach required changes or adjustments to...
In the 20 stories shared in the SenseMaker collection, it is in communication styles and ways of working where respondents feel that changes or adjustments are being made. Respondents also expressed the need for this to scale out to the wider system in a way that is sustainable in the longer term. This is to demonstrate system-wide impact as well as to provide a means of bringing people together to define a more connected approach.



"A background concern that colleagues express: all clinicians in our Care & Professional Leadership Assembly support the aims described in initial guidance, and our own independently derived recommendations to the ICS as to the place of clinical advice in driving the necessary changes.

Nevertheless, there remains considerable scepticism as to whether there will be a real realignment of power. Contrary forces of finance (ours is a very indebted system) and secondary versus primary care tensions have previously neutered clinical advice and prevented real change, and this has impacted health inequalities, access to care and outcomes across our system. There is an element of restructuring fatigue after STP, ICB and now ICS re-organisations."

Challenges and risks: timescale to evolve cultural transformation

> *"People protecting their own personal and organisational interests PLUS fear of doing something differently."*

There are some observations that the more implicit workings of power and marginalisation are not being attended to, and that these may present a barrier to the successful implementation of the guidance in the longer term.

> *"The same old, same old and another opportunity lost: my colleagues on the ICS inequalities board, particularly those from a public health background, began our joint working with a commitment to doing things differently. As time has gone by and membership of our group has grown, this initial determination has begun to be diluted. I suspect that it is because many people do not have a good understanding of how inequalities develop or impact on our client groups, and our processes are developed for the majority. There is little capacity (either in time or expertise) to understand how power operates to marginalise other groups or to hide the impact of social and material determinants of health."*

As noted in one focus group, 'culture' can be perceived in different ways, and can be difficult to verbalise. A key emerging theme here has been increasing the visibility of some of the more implicit behaviours and assumptions that guide actions and collaboration, to create a sense of shared identity moving forward.

This theme plays out on a wide scale, beyond individual behaviours. Whilst the guidance itself is deliberately permissive, to allow flexibility and build on existing structures, some participants are still encouraging the role of national support to give a sense of overall coherence to support distributed ways of working and maintain resilience and identity. It is noted in this report that challenging existing ways of doing things will take some time and careful learning to support these transformations, without relying on overly prescriptive guidance or leaving individuals feeling accountable too soon.

Examples of requests for national guidance include:

> *"More national support is needed to change historical ways of thinking, with guidance to support the broader care and professional leaders to take up leadership roles."*

> *"We need national guidance stating what must (or, better still, doesn't) need to happen to be compliant."*

How can plans shift the emphasis away from nested hierarchies and polarity and towards learning systems?

As the findings indicate, some cultural legacies and tensions present potential barriers to implementation, and there is a need to move from voices and representation to embedding and enacting the principles.

"Overcoming legacy culture barriers: a reflection on the way colleagues feel about the guidance so far: it seems to be wanted, welcomed and in principle how everyone feels we should be working. In practice there are historic barriers to implementation which appear to be cultural more than anything else. Bridging the gap between 'how things are', 'how things are perceived' and 'how people want things to be' , and not necessarily trusting the 'system' to enable it to happen. Part of my job has been to tell the leaders involved that it is within their gift to design it how they want it to look, but there is a reticence surrounding creating a utopia that may not fit with how things will actually be done."

As the creation of frameworks is still in many cases happening on a small scale, many of the participants in this research identified the need to join these efforts up into a wider system of learning with a more effective communication flow.

Part of the focus so far has been on learning from other processes and viewing the system from different angles by critically asking the right questions. With the need to enable understanding of different perspectives on the 'integration journey', trust will play a key role here, and this will be built over time, through ongoing interactions, accountability and action. **(East of England focus group)**

Who is sense-checking where we are at, and monitoring the journey to come?

Recognising that the guidance in some areas may be transformational if applied, but that it will likely take several years to fully be realised, was seen to be important to reassure staff and give them a sense of when to act. Many participants spoke of the need to expand and join up the learnings so far into a wider system of engagement, with ongoing reflection and 'pulse checks' being necessary for adapting strategy and practice. This is in line with the core values behind the principles, and making visible the more implicit workings of power that can often result in marginalising certain roles and/or communities.

The value of conducting research and reviews to amplify what's working well and to understand the wider impacts was noted, along with more micro-level reflections and "permission to fail and review in an ongoing journey" (SenseMaker exercise findings).

Case studies

Several case studies reflected the integration of Principle 2 in their ways of working, including offering opportunities for clinical and care professionals to lead and/or participate in a half-day workshop swap led by the Herefordshire Workforce Exchange Scheme.

"A GP was recruited for two sessions a month to lead the scheme and engage stakeholders. The LMC, Clinical Practitioner Forum (with representatives from across the ICS) and the Primary Care Network Leads all met and had input into the development of the scheme. The medical director of Wye Valley NHS Trust was enthusiastic, and recruited a consultant paediatrician who leads for medical education to help engage the consultant body. The emphasis on professional curiosity and relationship-building was conveyed through an animated video used to advertise the opportunity. More animations were produced to share this initial enthusiasm and recruit more doctors to the scheme, and eventually 30 clinicians signed up. An expression of interest form was used to work out common interests and allow pairs to be matched by professional and personal interests. Clinicians were introduced by email and encouraged to set dates. By November 2021, 24 exchanges had been completed with 12 pairs – constituting 10% of the Herefordshire doctor workforce. Nineteen clinicians submitted written feedback, which was universally enthusiastic, and in response to participant requests, a follow-up event was arranged to share learning."

'A Year in the ICS', developed by Nottingham and Nottinghamshire ICS, is a programme designed around a rolling 12-month calendar of themes (e.g., disease-specific, mental health, etc).

"The programme will look to tie in with national campaigns whilst acknowledging local priorities identified through our population health management insights and engagement with our communities. There will be a particular focus on conditions where prevention and self-care strategies can positively impact health and wellbeing outcomes. Other critical elements of the programme include:

-Inclusive and accessible design accounting for people with various needs: for example, people living with dementia disabilities, or sensory needs, and those who do not speak English as their first language.
-Linking in with ICS initiatives being developed to support the education and development of clinicians and the wider health and care workforce.
-Collaboration with the educational sector to develop a monthly learning programme in primary and secondary schools, linking closely with the PSHE curriculum.
-Building links with libraries, leisure centres, local sports clubs, and cultural and religious groups, and reaching out to underserved groups.
-Developing a network of local ICS Health and Wellbeing Champions working with local celebrities and clubs to raise the programme's profile."

The Big Room series of networking events led by the Mid and South Essex Foundation Trust is another example of this principle.

> *"The principle behind the Big Room is to bring teams and organisations together, mix them knowingly across the room, and generate opportunities further down the line. The idea is to get people together through social means and allow them to socialise and intentionally mix them (e.g., calling them in by alphabetical order, sitting them separately) so they can come together in a different way. Similarly, for a Community of Practice, the aim is to integrate clinical and care professional leaders and build relationships across the system over food/ meals with loosely educational purposes. If working under the assumption that the most important thing in an ICS is to create relationships, the Big Room offers the opportunity to create these relationships and space for people to come together and act as a catalyst to generate opportunities for further work to happen."*

Another good example of effective clinical and care collaboration and leadership was demonstrated with the COVID-19 vaccination programme, in which all five CCPL principles were effectively implemented. Staff worked in partnership with the VCSE sector, local authorities and other system partners, with strong managerial support available.

Top tips

Make use of software and digital platforms (e.g., Idea Drop) to address and encourage engagement in decisions and better share information.

A culture of trust and respect is integral, as well as a positive, safe and trusted environment where members have a voice and can raise their concerns.

A culture of shared learning can be promoted by utilising formal and informal networks and to maximise the impact of systems.

Co-creating procedures (SOPs and MOUs) is key to having a shared Integrated Care Board (ICB) vision.

The CCPL guidance needs to be embedded into each workstream, community, place, and into all patient care.

There is potential to use economies of scale to work together and commission one learning offer across systems.

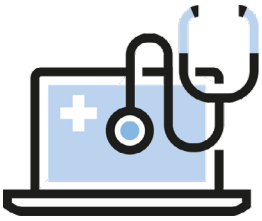
Use place-based diagnostics including place-based teams for discussions that can then feed up and out across the system. The promotion of small pockets of this, in a joined-up way, will stimulate local networks and lead to opportunities for change.

National support and clear guidance is needed to support distributed ways of working and maintain overall resilience and identity.

Investing in relationship-building is critical for success.

Principle 3: Ensuring clinical and care professional leaders have appropriate resources to carry out their system roles. Support clinical and care professional leaders throughout the system to be involved and invested in ICS planning and delivery, with appropriate protected time, support and infrastructure to carry out this work.

Key themes



Dedicated resources are needed to keep up momentum, engagement and communication within and between ICSs.

Working groups considered the different types of resource required for leaders alongside protected time and training opportunities, including the role of network connectivity and how various information and/or digital architectures might help to scaffold network connections in new ways, whilst also retaining knowledge and experience.

Clinical and care professional leaders also required dedicated time to find out what was available within their local and regional system, including networks, resources, etc. The importance of getting to know your system to facilitate its interconnectedness:

• by mapping out existing leadership networks so people know where to go)

• offering individuals a greater understanding of how to make links between these different spaces and professions work in appropriate ways,

• as well as understanding what leaders are working on/their priorities to prevent duplication and encourage collaborative working (e.g., Cornwall and the Isles of Scilly focus group) for example, the dedicated role of HR/OD (Human Resources Organisational Development).

Leaders also needed to be mindful of the system's position and demands placed on the system in terms of engagement events - business as usual can take priority. If funding allowed, external facilitators and outsourced professional expertise was regarded as helpful to facilitate conversations.

The need to ensure a clear definition of requests for clinicians to step into broader leadership roles has been crucial for success at a time of increased systems pressure. Examples of 'task and finish' groups, characterised by their small number of participants and a fixed timeframe for the group to complete a single objective, were shared. These professional networks and groups can benefit from having a structure and clear mandate. The importance of such groups for creating an environment of trust through working practice was also echoed in the focus groups.

On multidisciplinary clinical and professional leadership urgent care:

"Approach- to Urgent Care pressures in the system, set up a clinical leadership cell to drive some of the areas of improvement. Multidisciplinary in membership. Agreed number of task and finish groups, each of which was multidisciplinary and led by the most appropriate clinician or professional (for example, care package prescription and use of non-statutory support, led by an occupational therapist). Good cross-organisational and cross-professional working with ideas and plans that we would not have seen from a narrower

The Herefordshire and Worcestershire Allied Health Professionals Faculty shared an example of how they had generated funding and placement resources through diversifying the pool of clinical leaders sharing knowledge with students on clinical placements. The diversification of learning and problem definition eventually led to further funding opportunities and the securing of a dedicated clinical leader to support the talent pool.

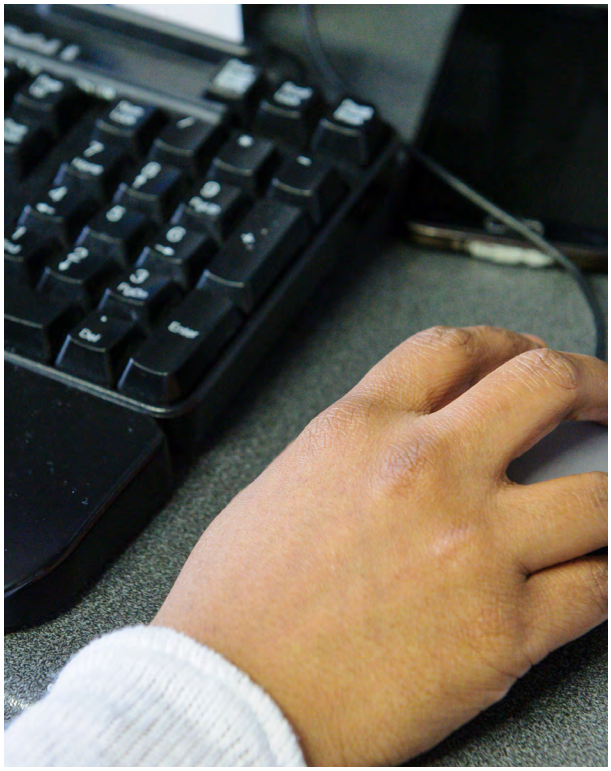
Collaborative Clinical Leadership enables rapid effective change – an Allied Health Professional Faculty:

"Whilst the AHP (Allied Health Professional) Council includes senior leaders from across health, social care and higher education to shape the strategic direction of AHP services within the ICS, the AHP faculty enabled a more diverse contribution from AHP clinical leaders at various levels specifically for workforce development issues. The faculty's first project focused on the expansion of student clinical placements for occupational therapy and physiotherapy undergraduates across the ICS. By bringing together clinical leaders directly supporting students in practice, staff were able to really understand the challenges they were trying to solve, share best-practice examples to decrease variation, and explore solutions from diverse viewpoints. The project delivered significant increases in placement offers, despite the pandemic, but importantly agreed upon an ICS placement allocation tool and placement charter to embed from the bottom up, with clear expectations and measurables and sustainable changes."

"By demonstrating the impact of this project, the AHP faculty raised its profile and influence as a clinical leadership group and has been able to secure national and local funding to continue its work. This has enabled provision of a dedicated clinical leader for the faculty for 12 months, who was recruited from within the ICS to support development of our own talent pool. This dedicated resource will be key to increasing the workforce intelligence and strategic workforce plans for AHPs within the ICS. This will ensure that the contributions of this workforce can be fed into and support ICS system improvement and new models of care delivery. Funding has further supported clinical leaders to deliver an ICS Return to Practice (RtP) project. Again, the success of this work has been due to the inclusion of a wide range of clinical leaders who have been able to engage the AHP workforce in a culture shift regarding RtP."

Dedicated resources are needed to ensure that professional networks are equipped to evolve.

Although a key part of the guidance points to the importance of equipping clinicians by giving them access to expert colleagues and data – such as data and data analysts or finance information and finance colleagues – not a huge amount of this was borne out in the research for this report. Examples of where this worked well came from the three Bedfordshire Luton and Milton Keynes Clinical Commissioning Groups (BLMK CCGs) in the East of England, to map out the clinical commissioning leads and, with HR and finance colleagues, to define rates of pay and create an offer for a mean level salary for the transition role they were moving to. The vast majority accepted the new role/rate of pay.



"With the creation of the Bedfordshire, Luton and Milton Keynes Clinical Commissioning Groups (BLMK CCGs), it became apparent that wide variation existed in the previous three CCGs' rates of remuneration. Our finance team then benchmarked our rates across the region and took a paper to the remuneration committee, the outcome of which was an agreed set rate. As the end dates of the 'contract for services' approached, discussions regarding BLMK rates were held on a 1:1 basis with each individual. Following these discussions, HR provided written follow-up with the requisite contractual requirements to reflect the new standardised rate.
Our aim is to extend the same generic pay rates across all HCPL roles, as we believe this is likely to attract high-quality leaders who will make improvements happen. However, this approach has not yet been agreed."

A further example from Nottinghamshire also demonstrates the impact of doing this on a smaller scale.

"In Nottinghamshire we established multidisciplinary working in teams based around primary care using data to identify risk and where action needed to take place. This was evaluated by Nottingham Trent University and demonstrated a reduction in hospital admissions and residential care home admissions, helping to deliver the outcome of promoting independence. There were also identified cost savings to the social care system in particular. The evaluation demonstrated the benefits of this multi-professional approach and some of the shared perspectives about this way of working."

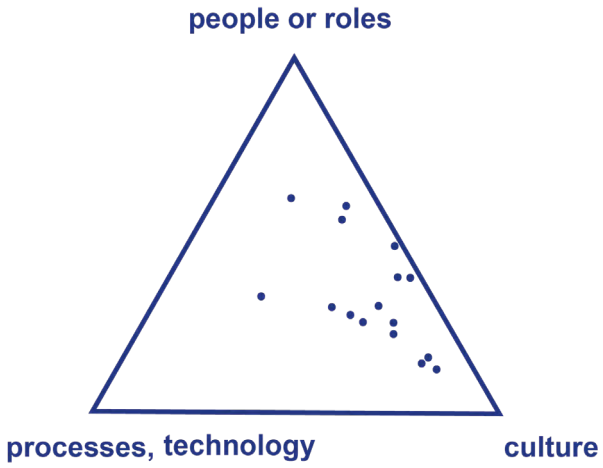
Challenges and opportunities

We identified among participants one major challenge: establishing a clear understanding of how the new roles are being received in diverse ways by various clinical professionals.

> *"We have incorporated all the principles in the way we have described the framework and development – influence/governance and engagement, transformation and strategy, and leadership and cultural change. It has been really well received, apart from in general practice. ICSs is a big change for GPs, and finding their new role is difficult."*

> *"Frustrating, and doing real harm to patients. Unfortunately, my experience is entirely negative, in that, as a whole, Community Pharmacy is ignored, and frequently actively excluded from primary care matters at local level. As a Primary Care Network (PCN) Community Pharmacy lead, I have struggled to make any contact with my PCN and, when I finally did, it was minimal and cursory. All services commissioned through Community Pharmacy which rely on GP or hospital input fail due to lack of response. No one seems willing or able to do anything to sort this."*

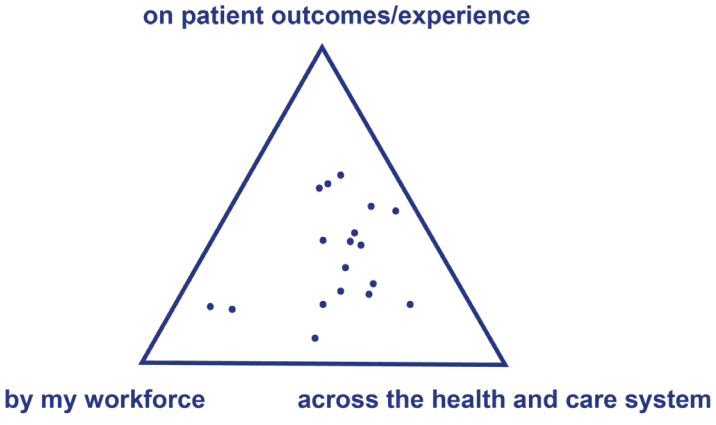
Some of the stories emerging through SenseMaker tap into this more implicit nature of power in the context of ICSs, reflecting on how the principles "are good core principles and they are the right core principles" in theory, but that in practice, there is still some way to go to culturally embed the changes desired. To create real change, it will be important to observe the impact on everyday cultural factors as a means of providing feedback on structural governance changes.



The key areas of concern centred on the resource requirements and timescales to implement significant change. There are concerns regarding competing demands across organisations in the system and the insecurity of funding forecasted for the next few years.

> *"Even though it's designed as one system, every part has its own issues and needs – a complete shift to single system working will take a massive amount of time."*

Reference was also made to uncertainty around policy drivers, and some people felt reluctant to implement changes before realising the implications of the change. This is not an uncommon state of affairs or environment in the public sector, and the health and care sector has a wide range of contributors, consultancies and think tanks that provide ongoing reviews and policy proposals, so a key question to address in the implementation of the CCPL guidance is how to manage related uncertainty from the outset, so that progress is maintained and supported. Ensuring that the different perspectives are made visible and capturing the emerging patterns across the multiple contexts of care delivery is deeply important.

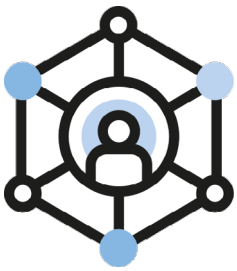


Case studies

Several ICSs demonstrated their implementation of Principle 3 across their system. Derbyshire's case study invested the dedicated resource in a full-time clinical director post to improve working relationships with the local GP community.

> *"Executive foresight to invest in this role, along with some management resource to support, was key. Identifying a leader with knowledge of both general practice and community services and the credibility to lead across both was essential.*
> *-Having a dedicated link for GPs to the community trust allowed the rapid resolution of issues that would previously have been 'escalated' through commissioners or personal links to senior leaders. Often these issues were simply misunderstandings, and having conversations not only prevented escalation but built stronger relationships.*
> *-Dedicated focus on 'old chestnuts' provided some quick wins. Examples include: some IT issues, once the cause was understood, were very easy to resolve. We noticeably reduced the annual confusion over who would vaccinate housebound people by brokering an agreement and ensuring it was remembered year on year.*
> *-Improving the capability of community trust managers, who often experience an imbalance of power between themselves and the GPs they work with. This involved peer support, role modelling, facilitation, and coaching approaches. This element was essential for changing the overall relationship and creating a shared improvement and learning culture between organisations."*

Another example can be drawn from the Humber Coast and Vale case study: Connecting the system to more of itself through a clinical and professional group.



> *"As a disconnect between CCGs and ICSs was identified, a Clinical and Care Professional Group was set up. Anything related to the system and its direction now the focus of discussions, with the aim of "connecting the system to more of itself."*

Case studies also highlighted the challenges and barriers ICSs face regarding resources.

> *"Our ICS is one of the most indebted ICSs in England. For the next financial year, we must make a saving of >4% on top of regular NHS efficiency savings. Developing clinical and care professional leadership in that environment will be a severe challenge."*

Top tips

Professional networks/groups benefit greatly from having a structure and a clear mandate.

Resources need to be allocated to ensure that existing networks are able to deliver and evolve.

Do not underestimate the difficulties involved in bringing clinicians together to engage in this type of work, due to work pressures.

It is important to get to know your system to facilitate its interconnectedness: map out existing leadership networks, giving individuals a greater understanding of how to make links between the different spaces and professions. Help people to understand what leaders are working on/their priorities to prevent duplication and encourage collaborative working.

Dedicated resources are needed for the ICS to keep up the momentum, engagement and communication.

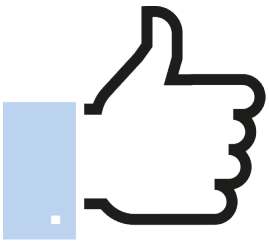
If funding allows, external facilitators and outsourced professional expertise are very helpful in driving the ICS work forward and facilitating these conversations.

Be mindful of the system position and pressures before organising any events.

There is a need to ensure that clinical and care professional leaders have the dedicated time and space to learn what is within their local and regional system, including networks, resources, etc.

Principle 4: Create a support offer for clinical and care professional leaders at all levels.

Key themes



There are expectations and norms around how leadership is valued and developed that differentiate between contexts and roles and that have implications for how frameworks and governance structures are developed. Creating the conditions for the right leadership behaviours to emerge in ways that also value the existing knowledge base is important to ensure representation is developed through practice.

Multidisciplinary groups are being shown how to tend to implicit cultural legacy factors by encouraging connectivity between silos or areas of work in ways that maximise role diversity and share these different perspectives.

The language used in the care sector is different to the language used by the NHS, which can create barriers to inclusivity in subtle ways.

The increased awareness of the need to create a shared language was described as a positive piece of feedback for one group to adapt practices moving forward. SenseMaker participants, and the focus group held in Cornwall and the Isles of Scilly, also pointed to the need to critically interrogate concepts such as ‘framework’, ‘representation’, ‘recognition’ and ‘leadership,’ and explain how they are seen from the different clinical professional perspectives.

"In Cheshire and Merseyside we held our first (of three) workshops this week. We had about 25 attendees from more than 15 disciplines across health and care. This is our design group (working with the North West innovation agency) who will engage more widely with colleagues. The workshop was more successful than we had hoped, and feedback so far is positive. One significant piece of feedback was on the use of language. Care sector colleagues all commented that the NHS speaks a different language to the care sector, and this makes them feel marginalised. There was also confusion about the term 'framework'. Depending on where you work, this means different things. Some associate the term with oversight and assurance, and it has instructive/prescriptive qualities. Some consider it a rule book, others a high-level set of principles. Few people seemed to think of it as a plan or as something iterative and long term (which is my interpretation of what we are being asked to produce)."

Learning through past and present experience in the spaces between disciplines and between clinical and non-clinical roles provides new strategies for identifying the different skill sets required. One SenseMaker participant found herself moving into a dedicated researcher role to facilitate this process:

"After qualifying as a non-medical prescriber with a Masters in Medical Sciences (NMP) in 2019, I found that there was a gap in any provision for ongoing support and development of NMP in primary care. I chose to do my dissertation on this for my Mmed (SCI) and conducted a systematic review of what best practice should look like. I have spent the last two years implementing the outcomes and changing the culture of what support and development means for nurses, pharmacists, PAs, paramedics and AHPs who prescribe or have an influence on prescribing in primary care. This has taken the form of setting up and running monthly lunchtime clinical teaching sessions around key topic areas, sitting as a clinical NMP and nurse on the local medicines optimisation group, running annual protected learning events around NMP, and collaborating with colleagues in the wider ICS to rewrite the NMP policy that will support this innovation and ensure that clinicians are supported and provided with high-quality, evidence-based clinical support with their prescribing. I presented this work at the RCN International Nursing Research Conference in September 2021. This work is all new, and developed as a result of my research. It was initially done in my own time, with no support or reward, for 12 months before I managed to secure a role in the workforce and development hub for one day a week."

Challenges and barriers

Barriers identified include “long-standing hierarchy and protection of individual organisations” and fear or conservatism around change. It was also important to consider how resources could be moved around to refill the backlog and provide support and dedicated leadership training and development.

The primary issues in this context are:

How to shift the model of education from one based on courses and certificates to one centred on dialogue, experiences and relationships	How to involve the voluntary sector and non-NHS staff in accessing training that may ordinarily have to be funded by organisations or individuals	Understanding the role of the patient and communities in describing how and what will most benefit them, and to enable shared processes that support this

Throughout the report we have been able to draw closely on the ways in which ‘academies’ are being used to lead the practice of developing and supporting clinical and care leaders, namely in Frimley, Bath and North East Somerset, Swindon and Wiltshire, and the Integrated Care Academy at Suffolk and North East Essex. However, these centres of learning require major resources. They should not simply be vehicles for mandatory or compliance training but should be genuine academies – critical, provocative and working at the point of most opportunity with people and places. There is limited training for the type of roles that can fulfil this ambition, and it must be explored within the resourcing of ICSs to ensure that transformational education is available to all.

Case studies

The Collaborative Newcastle System Leadership Development Programme case study is an example of a place-based programme that facilitates the development of collaborative relationships and supports innovative approaches to system-wide issues.

"Developing a programme at place requires an understanding of the behaviours and skills that will have most impact on the effectiveness of the local system. Multi-professional leaders complete a pre-programme engagement survey and a gap analysis highlights the leadership behaviours for development, thus recognising the skills required to work effectively across Newcastle.

The learning methods utilised on this programme encourage curiosity and creativity of thought. Clinical and care partners explore live strategic priorities and share their knowledge to develop transformational change ideas which are presented to, and often adopted by, senior stakeholders at the end of the programme. Throughout the programme the participants have access to coaching, shadowing and mentoring offers, and are encouraged to develop peer support networks. As the programme is owned by the partners and led and supported by the Collaborative Newcastle senior system leaders, there is buy-in and full support for participation and for continuation of collaborative learning and development beyond the delivered programme."

Reimagining the role of an academy

An academy is uniquely positioned as a catalyst for collaboration and support across the whole system, "functioning as a conduit". Thus, it is essential to ensure the academy remains neutral and semi-independent from the system governance, to avoid adding a layer of complexity to the system's culture. An example of this is the Frimley Academy case study.

"With its vision to nurture collective leadership potential and harness the power of people to create healthier communities, the Academy has developed a series of high-impact, multi-professional, system-orientated, and community place-based leadership development programmes that, with ICBs now on a statutory footing, can further harness the power of people to drive lasting health, economic and social improvements."

Top tips

Skills leadership need to be collaborative and distributive.

Commitment and buy-in from senior leadership are key.

It is important to align leadership with statutory demands and share the vision of the Integrated Care Board (ICB).

It is important for leaders to have some space and time for reflection/ reflective learning.

Build on the work created with CCGs, including making the most of clinical and care professional leader cohorts who undertook leadership development in the past and continue to build their leadership skills.

There is a key difference between system roles: clinical governance vs clinical leadership and transformation. These two are distinct roles and functions and need to be recognised as such. There is potential for a hybrid role of ICB members and clinical leads.

Roles and accountability need clarification. During the exit interview process with CCGs, staff highlighted individuals being unclear of their roles in transformation and their accountability for transformation.

A leadership development plan that includes expectations, mentorship and being co-produced would be helpful for leaders' development.

Importance of compassionate leadership and a culture of respect. The importance of 'value-based leadership' to widen out career trajectories (especially for AHPs) and send the message that 'leadership is for all' (Cornwall and the Isles of Scilly).

Consider the value of investing in action learning sets. A number of systems are currently developing these and extending invitations to mentors, system leaders and coaches to join.

It is important to have the chief roles (chief nurse, chief medical director) in place to continue with the ICS transition.

If there is investment in people's leadership development, those individuals will feel like they belong in the system. "The more is invested in leadership development, the better the culture becomes."

There is a need to increase pressure on providers to offer managerial support to the care professional group.

Consider line management structures so that traditional hierarchical governance structures are not accidentally replicated in new ways.

Make the connections between real-life activity and and the responsibilities of leadership, especially for roles crossing boundaries of the system, such as support nurses. A good example may be in navigating the political dynamics of leaderships, and influencing skills.

Principle 5: Adopt a transparent approach to identifying and recruiting leaders which promotes equity of opportunity and create a professionally and demographically diverse talent pipeline that reflects the community served and ensures that appointments are based on ability and skillset to perform the intended function.

Key themes

To harness the potential of the guidance to transform the way leadership is enacted across the system, there is a need to think about how the work happening now will feed more formally into structural opportunities and inequalities in the future, in relation to career progression. We noted that there is a recurrent acknowledgment that Principle 1 is foundational, and the subsequent guiding principles will facilitate how this unfolds; for a number of participants, the recognition of the need to be mindful that "we might not get this right first time around" was central, as was the need to reflect, on what is supporting this aim and what might need adapting.

> *"No matter how broad we scoped, there was always the concern it wasn't wide enough ...it requires a focus back on the 'why' we are doing this – because the old system didn't work and this is a chance to completely change how we lead. As it is a process of change it requires the usual techniques to allow early adopters and laggards the time to work it through, but against a background of impending organisational change."*

> *"We are having lots of meetings about improving flow, but they are not getting into what's happening with that single person and everyone's role in it – the ward nurse, social worker, family, patient. There is a disconnect. Those voices aren't represented."*

The Clinical and Care Professional Leadership (CCPL) guidance is seen to pave the way for more values-based leadership, putting the patient and place first to truly meet the needs of diverse communities, both in the health and care workforce and those seeking care.

Ways of promoting a diverse talent pipeline include: starting at an early stage by speaking to young people in schools and universities, mentoring, coaching, using social media channels, and promoting staff development and leadership programmes. One example of this type of programme is the Getting to Equity Sponsorship Programme, which connects existing talent amidst staff nurses and midwives (Band 8c and above) from ethnic minority backgrounds and helps them grow their career into senior or executive NHS leadership positions. Another type of connectivity is digital connectivity, which has been cited as a helpful means of joining these dots (e.g., via virtual meetings). There has been a huge rise in digital care provision, which was amplified by the COVID-19 pandemic, and looks set to continue.

Challenges and opportunities

Terms like 'distributed leadership' are helpful to orientate new ways of connecting and define future directions of travel, but many see that there is still some way to go for this to play out in practice in ways that do not replicate existing power dynamics.

> *"One of the key work areas I'm leading on is to address power sharing in senior levels – if it is all sitting in one part, why is that? It is important to understand the distribution of power in the system to be able to start to make a difference."*

One of the challenges in relation to Principle 5 is the recruitment of leaders who are representative of the population, but who also ensure that the workforce reflects the community they serve. Making leaders representative of the workforce is considered a key opportunity to provide staff with a sense of belonging, closely related to autonomy and being able to self-manage.

> *"Once they feel they belong, they bring their complete selves to work, and feel their work is worthy, and it helps incorporate the compassionate element.*
> *How to get people to have autonomy and self-manage? Belonging is a big part of that. How to create that sense of belonging? How to make them feel they're contributing something? How to celebrate their differences and successes?"*

Having representative leadership not only encompasses staff groups, but also service user representation in boards, committees and any key working groups.

> *"[Service users] need to be part of the team too. The system needs to centre around equity (Principle 5), to incorporate not only the voice of the people they're serving, not just the staff, but the patients themselves. Co-designing with service users – from the ground up and putting it all together, ensuring we have a consistent voice of the people we're serving and having an impact."*

Case studies

The North East London Foundation Trust (NELFT) case study provides a powerful example of inclusive practice (Principle 5), collaborating across the Ethnic Minority Network's Ambassadors and Champions, whose key aim is to help to improve the experience of staff from ethnic minority backgrounds. Some of the ways they do this include raising awareness and addressing local issues, identifying and setting plans to mitigate barriers to progression, acting as a first point of contact for advice and support, raising cultural awareness in the communities they serve, and removing invisible/ artificial barriers.

"The structure of the Ethnic Minority Network (EMN) includes strategic and directorate ambassadors and EMN champions who mirror the organisational structure. They provide support in addressing inequalities through partnership, working with leaders and teams at different levels. Our aim is to improve the experience of colleagues from ethnic minority backgrounds and ensure that equality, diversity and inclusion is embedded in every strand of the organisation, to lead to better outcomes for the people we serve."

Key outcomes from NELFT's EMN strategy and initiatives include change to 'include a scope of 9 out of 10 on equality, diversity and inclusion (EDI), lower levels of bullying and harassment from the public and from colleagues, compared to the sector's average, and higher equal opportunities for career progression when compared to the sector's average. NELFT's changes to it's recruitment processes have also resulted in improvements in applications for senior roles by individuals from ethnic minority backgrounds.

"As a result of the changes to our recruitment process, the relative likelihood of white applicants being appointed from shortlisting compared to BME applicants improved from 5.1 (2013) to 0.9 (2019), and the percentage of BME staff at senior level has increased:

- *Band 8b – from 8.2% (2013) to 28.6% (2019)*
- *Band 8c – from 2.4% to 38.6% (2019)*
- *Band 8d – from 7.7% (2013) to 37.5% (2019)*
- *Very Senior Managers (VSM) 0% (2013) to 23.5% (2019)."*

The Cheshire and Merseyside design thinking case study highlighted the use of an online crowdsourcing platform (Idea Drop) to support the development of the Clinical and Care Leadership Framework design group by allowing a diverse range of voices to contribute to the process in an open and transparent way.

"Recruitment and engagement plan for Idea Drop – wave two of recruitment campaign under way."

Top tips

Move away from an emphasis on 'management over leadership' to open up career trajectories.

Know how posts are being advertised and how to support the interview process around protected characteristics.

Build in holistic leadership development from the outset of an individual's career.

As retention becomes a crucial issue for the mentoring of the future workforce and leaders, encourage senior staff to share their stories about how they got to be where they are, to open up the possibility of moving in different directions.

Be inclusive and cast your net wide during recruitment and networking opportunities.

Create your own system's network of alumni to help influence investment and development of talent.

Set up advisory groups containing chairs from different professional groups and chief executives (e.g., executive chief nurse officer) to discuss concerns, challenges, best practice, forecasts, etc.

Establish professional forums (e.g., nurses, AHPs, social workers, administrative staff) that help 'cut the organisation into different layers' and ensure that staff groups are joined up across the organisation. These networks need to be brave enough to ensure that every individual feels like they belong to a group and can rely on having that space.

Promote the recruitment of a diverse talent pipeline by engaging with different platforms, starting from schools, universities and social media, as well as promoting current staff via development and leadership programmes, coaching and mentoring offers.

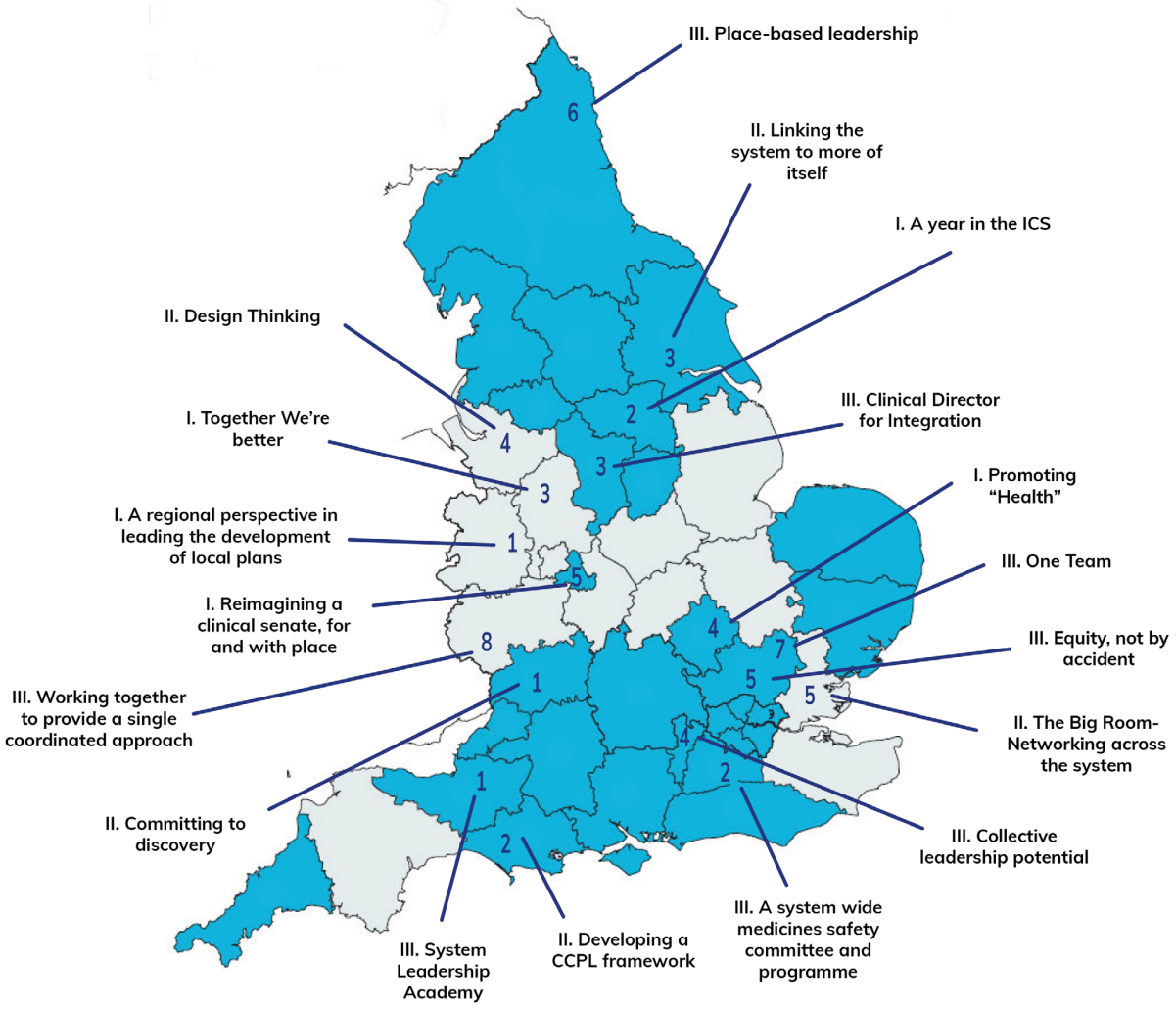
Chapter 2 – Approaches and case studies

Guide to case studies

In the following section, we will provide an overview of our case studies. Our categorisation of examples is not designed to reflect the status of framework development, nor do we propose that a system cannot be in more than one category (in fact, most are).

The examples are organised in a way that we think provides the best opportunities to learn from a particular aspect of their development and reflects a balanced set of contributions from across all regions.

The following table describes our current portfolio of case study organisations, with titles and contact details. It is important to note that the CCPL principles highlighted by the case studies are not exhaustive, as several of the principles may be reflected in all case studies, but we wanted to flesh out the principles more clearly identified by each case study.



I. Emerging frameworks	Title	Contact
1. Midlands	A Regional Perspective In Leading The Development Of Local Plans	jessica.sokolov@nhs.net
2. Nottinghamshire	A year in the ICS	rosa.waddingham@nhs.net
3. Stoke and Staffordshire	Together we're better	leanda.adams-collett@staffsstokeccgs.nhs.uk
4. Bedfordshire, Luton and Milton Keynes (BLMK)	Promoting 'health'	penny.emerson3@nhs.net
5. Birmingham and Solihull (BSol)	Reimagining a clinical senate, for and with place	william.taylor3@nhs.net

II. Frameworks in design – approaches to method	Title	Contact
1. Gloucestershire	Committing to discovery	mark.golledge1@nhs.net
2. Dorset	Developing a CCPL framework	francesca.pingarelli@Dorsetccg.nhs.uk
3. Humber Coast and Vale	Linking the system to more of itself	nigelwells@nhs.net
4. Cheshire and Merseyside	A method to apply design thinking	jen.kohan@innovationagencynwc.nhs.uk
5. Mid and South East Essex	The Big Room – Networking across the system	a.griffiths12@nhs.net

III. Principles in practice	Title	Contact
1. Bath and North East Somerset, Swindon and Wiltshire (BSW)	System Leadership Academy	nicola.jakeman@nhs.net
2. Surrey	A System-wide Medicines Safety Committee and Programme	nikki.smith24@nhs.net
3. Derbyshire	Clinical Director for resourcing a Integration	ian.lawrence@nhs.net
4. Frimley Academy	Creating the conditions for collective leadership	robert.cowan1@nhs.net
5. North East London NHS Foundation Trust (NELFT)	Equity, not by accident	harjit.bansal@nelft.nhs.uk
6. Collaborative Newcastlet	Place-based leadership	jill.cordes@nhs.net
7. Suffolk and North East Essex	One Team	mark.shenton@NHS.net
8. Herefordshire GP Leadership Team	Working together to provide a single coordinated approach	jan.bailey@taurushealthcare.co.uk

1. Emerging frameworks

In this section we present a selection of case studies that, although each is at a conceptual level, reflect different approaches to the development of a framework, reinforcing how and why place and context are critical, and the scope of opportunities that exist when design and development placed centrally to the process of governance. The majority of these are drawn from the Midlands: we wanted to spend some time elevating the high-quality regional leadership that has supported the pursuit of, in some cases, genuinely ambitious plans to reshape health and care.

Case study

1. Midlands – A regional perspective

As part of the group who reviewed the First Wave' report on ways of working in COVID-19, Dr Jess Sokolov saw first-hand the opportunity for change and the value in promoting a culture that can routinely demonstrate agility, autonomy, collaboration and support for leadership at all levels.

In parallel, the conversations and policy development around moving from a Clinical Commissioning Group (CCG) model to an ICB model continued, and there seemed to be a gap in knowledge and learning around the role of clinical leadership in this shift.

Using the opportunity to bring together system clinical leads, an informal group supported the development of the principles that the Midlands could use to inform its development of clinical leadership, and this led to a role for Dr Jess Sokolov in the steering group for the national guidance. In this way, many of the conversations in the Midlands were reflected at the national level.

As the conversations continued and roundtables were established, the leadership group identified a need to model the multi-professional characteristics that were being reflected back to them as being important, and this led to two further roles working alongside the medical director – a chief AHP and chief pharmacist – and more engagement with regional leads in all disciplines of health and care, tapping into the networks and communities in place.

These conversations with system clinical leads led to a regional investment in action learning sets as the primary vehicle for developing system approaches to framework design that could meet the expectations of the newly published CCPL guidance. NHS Elect subsequently delivered three action learning sets in each system, sometimes more when commissioned by the system, and operated flexibly to support the application of learning towards a framework and local plan.

The ongoing regional meetings, the continued investment in a regional leadership team that reflected the principles of the guidance, and the momentum captured through the engagement with the First Wave report and its learnings, supported a regional response that is progressive, mature and reflective of both the region and systems, and led to a distinct set of relationships that are at the same time local and global in scale.

Case study

2. Nottingham and Nottinghamshire – 'A Year in the ICS'

Background

Our programme 'A Year in the ICS' builds on the five design principles for clinical and care professional leadership, the shared purpose of our ICS and our own clinical and care professional leadership framework and principles. Our health and care partners came together in 2016 in a Sustainability and Transformation Partnership (STP) which evolved into an Integrated Care System (ICS) in 2018. The NHS and social care are working with other public services, including schools, the voluntary sector, housing associations, police, and fire and rescue services, covering a diverse mix of cities, towns, villages and rural areas.

The ICB is establishing a Partnership Agreement to demonstrate it's commitment to working effectively together for all our communities. Leadership teams are tasked with creating a system-wide strategy for engagement and co-production with people and communities. Voluntary, community and social enterprise (VSCE) organisations bring a wealth of knowledge, experience and creativity that can facilitate the design and implementation of strategies to tackle health inequalities, help to promote engagement with communities, and support the care of patients with complex needs.

Our approach

The inspirations for the programme 'A Year in the ICS' were a workshop run by David Meates, former chief executive of Canterbury Health System in New Zealand, and David Hockney's exhibition 'A Year in Yorkshire'. The programme is designed around a rolling 12-month calendar of themes. These may be disease-specific, such as 'diabetes', or broader: for example, mental health. The programme will look to tie in with national campaigns whilst acknowledging local priorities identified through our population health management insights and engagement with our communities. There will be a particular focus on conditions where prevention and self-care strategies can positively impact health and wellbeing outcomes. Other critical elements of the programme include:

Inclusive and accessible design to account for people with support needs: for example, people living with dementia, disabilities, or sensory needs and those who do not speak English as their first language.

Collaboration with the educational sector to develop a monthly learning programme in primary and secondary schools, linking closely with the Personal, Social, Health and Economic (PSHE) curriculum.

Developing a network of local ICS Health and Wellbeing Champions working with local celebrities and clubs to raise the programme's profile.

Utilising the expertise of our universities to help with the evaluation of the programme.

Linking in with ICS initiatives being developed to support the education and development of clinicians and the more comprehensive health and care workforce.

We recognise the value of previous learning and build on local and national initiatives developed and implemented. We recognise the importance of place-based partnerships and work with them to deliver locally sensitive solutions.

Looking at innovative ways to partner with our local businesses in an inclusive way that does not prioritise those who may be able to invest resources.

Building links with libraries, leisure centres, local sports clubs, cultural and religious groups, and reaching out to underserved groups.

Challenges

We recognise some significant challenges that we will need to address and overcome if we are to be successful. The following challenges have been identified:

- System challenges and senior leader support
- Conflicting current and new priorities across the system
- The tension between PCN, place and system leadership
- Insufficient evidence on key outcome measures to support the continuation of the programme
- Communication and engagement challenges
- Poor engagement within our health and care workforce and communities
- Disproportionate engagement between our most and least deprived communities
- Lack of financial resources dedicated to the programme
- Insufficient protected time in job roles to support programme development and delivery

We recognise that delivering strong, clear, bespoke messages about the programme is fundamental to overcoming these challenges. Equally important is providing reassurance that the programme aims to build on existing initiatives and good practices and places equal value on PCN, place and system.

Impact measurement

'A Year in the ICS' allows us to increase patient and public activation to progress the ICS's health and wellbeing outcomes and meet the ICS's strategic priorities around prevention, self-care, and tackling health inequalities.

Evaluation of the programme will include quantitative measurement of short-medium- and long-term outcomes, recognising the need to take a long-term view to record improvements in outcomes in population health and healthcare. Qualitative analysis of the opinions of staff, patients and carers will provide evidence of culture change that supports behaviour change. We are working with partners, including our universities, to identify ways to measure this as the programme

Next steps

We are currently focusing on our June launch event and building our approach for the rest of the year, utilising the networks, forums and people within our systems to maximise our impact. Once we are up and running, the potential for this work will become apparent, but given the success of the Canterbury approach that this is based on, we are hopeful that it will be a fundamental enabler for change in our culture and system.

Case study

3. Stoke-on-Trent and Staffordshire – 'Together We're Better'

Background

Our priority is simple: residents must come first. We want to deliver person-centred care close to home and ensure it's delivered in a joined-up way. We also want to give patients confidence that the changes being made are the right thing to do for them and health and care staff. Work has focused on the five principles to form a new model for the future ICS programme, 'Together We're Better'.

The ICS evolved from and built on the Sustainability and Transformation Partnership from 2016. We know there is much more work for us to do before we are truly an integrated system. We will continue to work with our partners to design our local approach over the coming months. There will be a much greater emphasis on collaborative working to manage resources, performance and delivery to change the way health and care is delivered – for the better.

Our approach

The Clinical and Professional Leadership Programme has structured its development portfolio around three core programmes mapped to the guidance principles:

Governance and Engagement (Principles 1 & 3)

During 2020/21, the Staffordshire and Stoke-on-Trent Health and Care Senate (SS H&CS) was established. The SS H&CS is multidisciplinary and extends across health and social care, comprising senior doctors and nurses and representatives from social care. Primary and secondary care clinicians are involved, as well as representatives of local authorities. The SS H&CS is supported by three Health and Care Assemblies (H&CAs) and aligned with three place-based partnerships (PBPs). The H&CAs will provide a broad group of health and care professionals to support transformation delivery at the PBP level.

This is a different way of working from what has superseded it, and the multi-professional aspect is key to this. The model does not address the strategic direction for individual professions, and communication around this has had to be strengthened. The Clinical and Care Professional Leadership framework has been widely engaged within the Staffordshire and Stoke-on-Trent clinical and professional community; feedback will influence the future development of the model and framework.

Transformation and Strategy (Principles 2 & 3)

The strategy will set out our areas of focus for system clinical transformation and strategic commissioning; a process has been put in place to determine these priorities. It was recognised that there are multiple priorities at system, organisational and place level: these need to be put into a unified integrated care strategy that all partners can support and deliver.

Leadership and Cultural Change (Principles 2, 4 & 5)

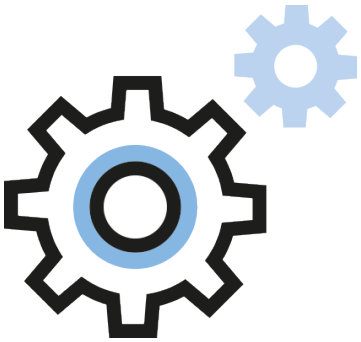
The emerging clinical and professional leadership model for Staffordshire and Stoke-on-Trent has been developed by a multi-professional, cross-county working group sponsored by the SS H&CS.

It is also supported by a managerial project team, including a strategic workforce representative, finance representative, and a communications and engagement representative. The emerging clinical and professional leadership model aims to meet the following core objectives, aligned to the national principles:

- Underpinned by quality at every level
- Supports open communication and dialogue between System-Place-Neighbourhood
- Multidisciplinary and diverse from both a professional and an organisational perspective
- Appropriately resourced from a financial and time perspective
- Has transparent governance between system and place
- Embedded in a supportive, inclusive and collaborative culture.

Challenges

The resource for shaping, developing and progressing the work programme has been an 'add-on' to people's day to-day-roles. It will need more focused and dedicated resources moving forward to ensure that progress is embedded and sustained.



Impact measurement

Success will be measured through the following:

Culture change – the senate and Assemblies will carry out 360 feedback annually to ensure that the relationship is effective and supports change both across the system and at place.

Delivery of ongoing engagement events to develop networking opportunities and gain feedback.

Delivery of a model that is truly multi-professional.

Identification of new and emergent leaders – the ICS is exploring how to maximise new and existing leadership development opportunities to support a pipeline of new leaders.

Delivery of outcomes identified through individual portfolio work, as defined through the transformation strategy.

The framework and model were set to be agreed in spring 2022.

Lessons learnt

Critical enablers for success were:

The establishment of the governance structure from the start, including both the H&CS and H&C Assemblies at place. This has given the programme of work the requisite profile and provided the strategic direction and steer needed at every stage.

The establishment of a cross-county, multi-professional working group, sponsored by the senate, which enabled the work to move at pace.

Engagement with wider professionals at an early stage to gain feedback and support for the framework and model and develop networks.

Case study

4. Bedfordshire, Luton and Milton Keynes – Promoting health

Background

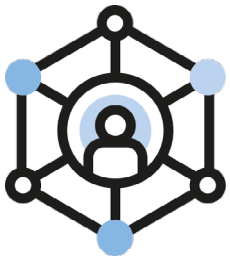
This case study outlines the approach we have taken to date in establishing our Health and Care Professional Leadership Programme (HCPL), which we believe describes the inclusive multi-professional leadership development framework we wish to deliver. We are doing this in partnership with our four local authorities, NHS organisations, residents, and the voluntary sector alliance.

HCPL is central to designing and delivering integrated care. A range of health and care professional leaders from diverse backgrounds should be involved in decision-making to contribute towards a collective ambition for the health and wellbeing of our population and improve outcomes.

Our approach has built upon the broad range of initiatives, roles and current structures working well across our system. We recognise that although we have some excellent initiatives, these are not always consistently or systematically embraced. We can do more to deliver our strategic objectives, and the principles set out in the CCPL guidance.

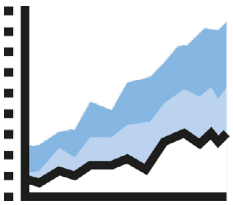
Our approach

Programme design



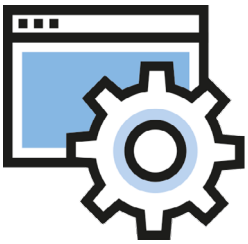
Collect phase

This phase included programme set-up and launch, governance, stakeholder analysis and engagement plan, programme interdependencies, benefits and metrics. Outputs of this phase inform the delivery of the structures and communication mechanisms to connect leaders at each system level.



Collate phase

This phase focused on bringing together the outputs of 'collect', together with alignment against our integrated care strategy objectives, 'good' framework features and a new distributed leadership model. Outputs of this phase inform the delivery of the skill sets required for our current and future HCPLs and the overarching content.



Curate phase

This phase focuses on developing our framework and implementation plan.

Governance

The programme is overseen by our HCPL steering group, formed of 18 executive directors or senior officers from ICS partner organisations and chaired by our chief medical director for the new Integrated Care Board. Its essential purpose is to develop our Bedfordshire, Luton and Milton Keynes (BLM) offer for HCPL across the system, building on current initiatives and creating new and innovative opportunities to develop, support and integrate our new and existing HCP leaders. The group aims to create a culture of shared learning, collaboration and innovation, working alongside patients and local communities. The group will ensure that HCP leaders have appropriate resources and dedicated leadership development, creating a pipeline of HCP leaders. The steering group reports to the BLMK ICS CEO Group and Partnership Board.

We are also currently mobilising our Health and Care Senate to provide HCPL and advice to our Bedfordshire, Luton and Milton Keynes (BLMK) ICB. It will also have a role in ensuring that the HCP voice is heard at every level of the ICS. The senate will act as an advisory group, taking representation from each health and care professional discipline to ensure engagement. The group can advise on system-wide service transformation proposals before their approval at ICP/ICB. With alignment to place-based health and care leadership groups, the senate will help develop health and care-led solutions and potential opportunities for improvements, ensuring the system develops robust clinical proposals.

We have two emerging care alliances, and each has been considering how best to ensure that HCPL is at the heart of their work. An aligned governance structure is currently being developed, supporting the care alliances to fully connect with the needs and residents.

Roles and uniform remuneration policy

Our BLMK ICS mission is to improve population health, promote equality in the health and wellbeing of our population, and enhance productivity, effectiveness and value for money. All future leadership roles will therefore need to contribute to these aims. With the creation of the BLMK commissioning collaborative (the evolving BLMK Clinical Commissioning Group, CCG), it became apparent that there was wide variation in the previous three CCG's rates of remuneration. Following benchmarking across the system, our primary care team, working with and supported by the finance team, took a paper to the remuneration committee to agree a transparent and fair rate across all practices/PCNs.

We aim to extend the same generic pay rates across all HCPL roles, as we believe this will likely boost high-quality leaders who will make improvements; however, this approach has not been agreed upon yet. We are currently working to develop standardised role descriptions for our HCPLs. We have already commenced standardising pay rates, albeit only for commissioning clinical leaders at this stage.

Challenges and lessons learned

Our HCPL programme has created several challenges and we have learned many lessons as we have moved through the design process.

Clarity of purpose
Clearly articulating the aims, objectives and benefits in a persuasive enough way for senior system partners and CEOs.

Who to involve
Given the five principles, the programme's scope is vast. Getting people involved and engaged across the spectrum can be challenging. We have had to find our champions.

The importance of good relationships and a common purpose
This cannot be overstated. Maintaining relationships and momentum in the face of COVID-19, the abolition of CCGs and the formation of the ICB can be tricky.

Cultural change does not happen overnight
Co-producing our Organisational Development (OD) initiatives and aligning with our People Plan delivery will take time.

Build on success
Our AHP Council is well established and mature, with well-motivated leaders. We have a global centre of excellence for social work research at Bedfordshire University, and need to ensure we bring this success to a wider audience. Our 'Leading Beyond Boundaries' programme has already delivered success.

Case study

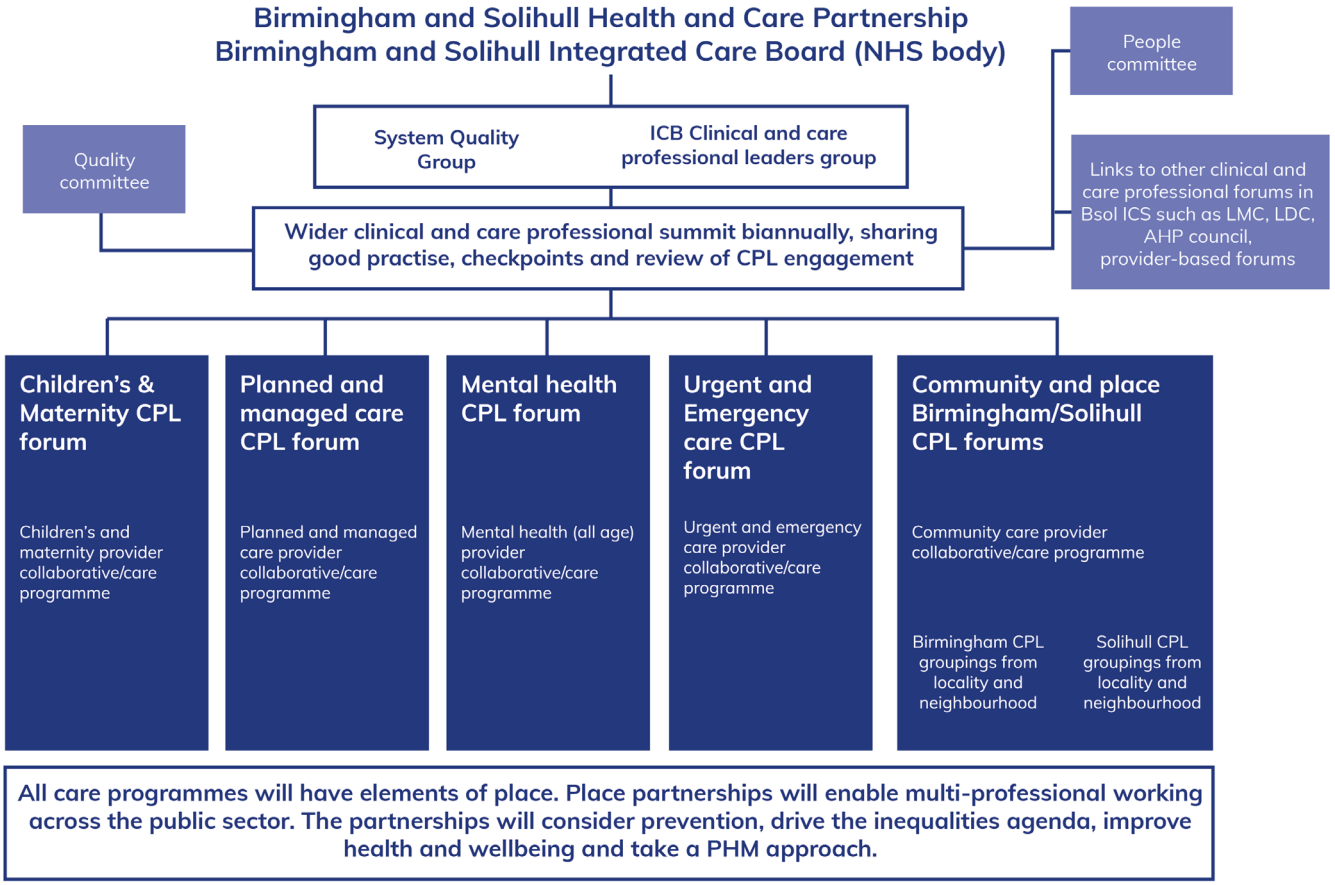
5. Birmingham and Solihull Mental Health NHS Foundation Trust – Reimagining a clinical senate, for and with place

We wanted to create a system where CCPL was a core function of the ICS and that was broadly representative. In early models we consulted with the wider CCPL community. We set up a clinical senate that sat alongside the ICB and was fully representative of the spread of CCPL in the system.

As we developed this, it became clear that the senate did not have a defined overall purpose. Also, to be fully represented in the way we envisaged, it would need to include about 50 people, and a large proportion of those would come to meetings to sit through topics that had no relevance to them and their expertise.

CCLP is a finite resource and must be used well. We have moved these clinical forums nearer the speciality/place they are related to, where they feel they have more value to those who participate in them, and they are closer to the people they serve.

This is still evolving, but it now feels like a much more functional approach that works for clinical and professional leaders. We feel it is important not to say that any of these structures are set in stone; we accept they will evolve as we test and improve them, and this is integral to our approach.



GP Provider Partnership Board

A good example of how we are structuring our systems to allow professions to engage and have a 'single voice' is our development of the GP Provider Partnership Board above. The ICS has supported general practice to organise itself to allow a clear voice from practice level, up to Primary Care Network (PCN) through their clinical director to locality and into a GP Partnership Board, which then nominates GP clinicians to sit on the ICS representative bodies. This system has been signed up to by 100% of GPs.

Strategy and governance

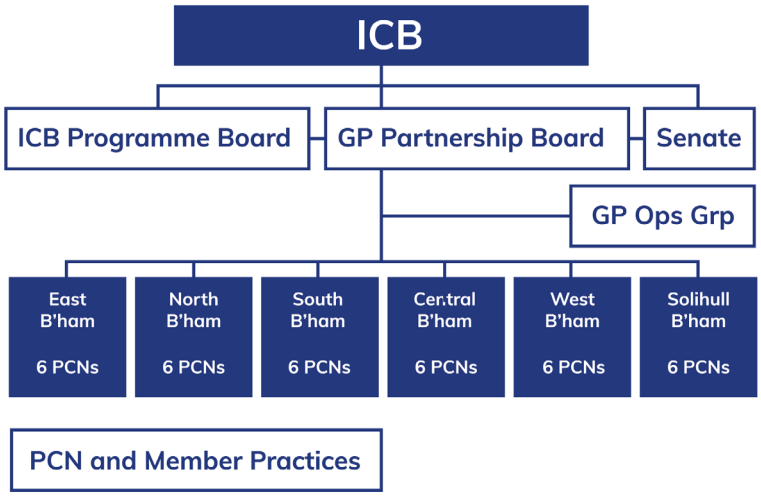
- GP perspective to influence system strategy and direction
- X12 GP reps identified with a mandate and skills to contribute to the Partnership Board terms of reference
- GP board has a direct relationship with ICS structures and programmes

Tactical level

- CDs and PCNs working with partners to address local priorities and inequalities

Operational

- Implementation at PCN/neighbourhood level



Philosophy of care

We have developed a 'philosophy of care' as a tool for all professionals in the system to get behind and feel engaged with. This will inform the visions and values of the ICS. We held two large workshops (30–40 people) to develop this. It has exceeded our original plan and become a clear marker in the sand about the high quality of care we want to see. It is of course a view from a clinical and professional angle, but it has gone on to inform the vision and values of the ICS and our wider strategy.

BSol CPL philosophy of care

One caring community

"Together we make a difference. Together we enable good health, save and improve lives. Together we ensure equity of access to outcome-focused high quality care centred on the whole person."

Access to care

- We will provide the best possible experiences of care
- We will ensure a focus on equity of access for all
- We will prioritise access for those with the greatest need

Seamless care

- We will work together to achieve care that feels seemless, with simple transitions between organisations
- We will work together cohesively and collaboratively, regardless of who we are employed by

Prevention

- We will empower and support people and communities to take positive action to live healthy lives
- We will focus on the factors that contribute most to the health ineqalities our communities face

Personalised care

- We will ensure that care is tailored to the specific needs of individuals within their communities
- Our care will take into account the whole person, recognising the significant impact of the wider determinants of health

High-quality care

- We will ensure our collaborative efforts are focused at all times on aiming to achieve high-quality, evidence-based and compassionate care to deliver the best outcomes and experience for our patients
- We will take care of our staff, recognising that our staff are part of the communities we all live in

II. Frameworks in design – approaches to method

In the following section, we present a further series of case studies that outline approaches and models aimed at the development of local plans. In this, we have attempted to bring to life the nature of development where both place and system are central, and engagement is informed by the ideals of co-production and elevating collective voices, many of which do not have the influence that can facilitate change.

Many of these are works in progress, and all contributors were very clear in acknowledging that this is the start, not the end point, of the design process. There are deep and enduring issues, with historical barriers and limitations, but what has impressed us the most is the openness system stakeholders display when creating spaces and opportunities for change to be led by those that are most affected by its delivery – communities, patients, local organisations and partners.

Case study

6. Gloucestershire – Committing to discovery

Background

Over the last few months, Gloucestershire ICS has been developing its local framework for clinical and care professional leadership. The approach taken has built on what is already working well, whilst considering what can be developed further for the future. In 2018, Gloucestershire became a wave two ICS. It has a history of collaborative working across partner organisations. For ICS purposes, Gloucestershire is defined as both 'system' and 'place'. Gloucestershire has six Integrated Locality Partnerships (ILPs) that are broadly aligned around district council boundaries (within which the 15 Primary care networks form part).

For some time, Gloucestershire has sought to ensure there is a strong clinical and care professional voice throughout all levels of decision-making, including:

ICS Transformation Programmes that are about redesigning health and care pathways.

Integrated Locality Partnerships (ILPs) that take a strong population health management approach and focus on what matters to local people.

Clinical and Care Professional Council and Professional Groups (such as AHP Council, Nursing and Midwifery Council) that seek to ensure a strong clinical and care professional voice in the system.

Appointment to key leadership roles, including a Chief AHP Lead across the ICS. The ICS has also recently appointed an ICB Chief Medical Officer and an ICB Chief Nursing Officer.

Our approach

As a system we have defined clinical and care professional leadership based on the following three areas:

1. **Clinical and care professional leaders representing and facilitating professional networks** to ensure a strong professional voice across the ICS (e.g., AHP Council).

2. **System clinical and care professional leadership within Integrated Locality Partnerships** to identify and respond to population health needs.

3. **Clinical and care professional leadership redesign outcomes** and support.

The development of the framework has explored opportunities to strengthen clinical and care professional leadership in these areas. The approach to development of the future framework for clinical and care professional leadership has involved three key activities:

1. **Engagement with existing clinical and care professional forums**
   Gloucestershire already has well-established forums that bring together clinical and care professional leaders. The Clinical and Care Professional Council (which has recently been broadened to include children's social care, adult social care and representation from the care provider sector) has overseen the work, with executive leadership from the Chief AHP Lead and the ICB Chief Medical Officer (Designate).

2. **Survey of existing clinical and care professional leaders**
   In December 2021, a survey/stock-take of clinical and care professional leaders was carried out based on the five principles identified within the guidance.

3. **An** External Peer Challenge was facilitated by the Local Government Association (in partnership with the NHS Confederation and NHS providers) of our clinical and care professional leadership arrangements.

Challenges

The capacity of existing clinical and care professional leaders to engage in the approach, given the wider health and care pressures.

The time needed to engage with a wide range of professional groups – including the time needed to prepare for an external peer challenge.

The complexity of funding arrangements for clinical and care professional roles, ensuring that these roles are open to all professions (this was also identified as a challenge by other systems).

Lessons learned

The benefits of having an external peer challenge
It's not an inspection, but the review is challenging, and peers ask probing questions to understand what is working well and where there are opportunities for improvement.

The benefit of having a range of external peers
The Gloucestershire peer review included peers from a variety of clinical and care professional backgrounds including adult social care, medical, primary care, mental health, and children's social care.

The need to have a cross-section of stakeholders involved in the peer review
The 13 focus groups covered a range of stakeholders across a variety of professional groups including AHPs, social care providers and local authority.

Next steps

The outputs of the survey and external peer review (including peer review report) have formed the basis of the framework for clinical and care professional leadership in Gloucestershire. As part of the framework, an action plan has been developed with actions aligned to the five principles. These include the following:

Principle 1
Work has already been undertaken to closely align clinical and care professional leadership roles to the ICS transformation programme structure. Further work is planned to publish the full list of who holds clinical and care professional leadership roles and explore how the AHP model of professional leadership can help other groups strengthen their professional voice.

Principle 2
The findings have identified examples of existing collaborative working. Further work will build on this and develop our approach to co-production with people and local communities.

Principle 3
Further work is planned on exploring how support areas (such as business intelligence, finance, programme management) can assist clinical and care professional leaders in their roles.

Principle 4
Positive feedback has been given on the existing clinical and care professional leadership opportunities, but future work is planned to support further promotion of these and use the work on the ICS People Plan to empower leads to take up available opportunities.

Principle 5
Recent work has been undertaken to recruit a number of clinical and care leads using a transparent process and common role description. Work will build on this to support leadership development for the future.

Case study

7. Dorset – Developing a CCPL framework

Background

In Dorset, we have procured Deloitte to design and run engagement work to ascertain where we are in terms of maturity as a system in relation to the CCPL framework principles. We are part way through running a series of engagement events to find out from our clinicians where we are against the principles in the framework. After this discovery phase, there will be a design phase to identify which interventions should be prioritised to improve the system's position against the principles. Even though we have only just started this journey, we have already learned some critical lessons learnt around engagement and connectivity.

This project is part of the Clinical and Professional Leadership workstream within Dorset's wider ICS development programme, which aims to deliver the national requirements to enhance the clinical and professional leadership models within Dorset as our ICB becomes formally established. It is governed by a System Partnership Board, ICS Programme Board and Dorset's Clinical Reference Group, made up of key professionals across the system.

A key piece of work commencing within the ICS Transformation Programme is developing our local Clinical and Care Professional Leadership Framework, which will set out how the five principles for clinical and professional leadership will be embedded within the Dorset ICS. It will take learning and experience from our current ICS and CCG structures to ensure we are best placed to sustain and transform our services to meet the needs of the Dorset population. Some initial scoping locally has been carried out.

Our approach

By May 2022, current deliverables include:

Produce a robust co-production and engagement plan that will set out how the CCPL framework will be co-produced within the defined time frame for sign-off at Clinical Reference Group.

To undertake a series of engagement activities to co-produce ideas that would enable the system to meet maturity requirements across each domain.

To identify and be explicit about how this framework aligns, informs, and is informed by, other work programmes across the broader ICS transformation programme.

Provide a critical analysis and identify the key themes to be addressed to meet the maturity requirements across each domain. Produce an associated delivery plan that sets out high-level short-, medium- and long-term deliverables that will form our local framework.

Ensure the final draft is ready to run through governance processes to enable the system to submit by the required deadline.

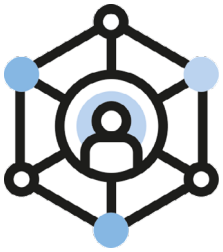
The design outputs will be delivered via existing programmes of work and mechanisms. For example, there is separate work relating to developing the ICS culture across the system, which will be done using a dialogical OD approach and contracting with the new ICB and ICP. The outputs of the relevant parts of the CCPL discovery and design will feed into this cultural audit and development plan. We have an existing ICS People Plan and operating model, and it is likely that most outputs from the CCPL will be delivered via this operating model.

Challenges

Key challenges include:

Using effective communication media/channels to reach all disciplines.

Identifying the connections and synergies with other programmes and ensuring that we do not duplicate these.



Engaging a breadth and range of clinicians from across the system, mainly due to current system pressures. This has led to some creative thinking in increasing engagement through focus groups, 1:1 interviews with clinical leads, and a wider survey.

Impact measurement

As Myron Rogers states in his maxims, “The people who do the work do the change” and “The process you use to get to the future is the future you get”. Therefore, the dialogical and highly participative methodology will be the start of the change we aim to achieve, and this is linked to the first principle.

There will be a range of measures explored during the design process and the framework itself outlines what 'good' looks like. We will be able to attribute these to a range of qualitative and quantitative measures as the design is completed. But some that we can identify will include:

- Improvements in responses to follow up focus groups and surveys
- The cultural audit will also provide a significant number of agreed measures
- Future take-ups and engagement in similar processes
- Take-up in development opportunities
- Staff experience and system relationships

Lessons learned

It is still early days but already some lessons are being learned:

- Outsourced professional help to drive this type of work forward is really beneficial
- It's helpful to have someone external to facilitate these conversations, especially in a smaller system
- Difficulty in bringing clinicians together to engage, due to work pressures
- Be cognisant of the system position and pressures before launching engagement events
- Ensure there is good connectivity to existing relevant workstreams across the system
- Keep the group delivering the work tight and keep communication regular

Next steps

The approach taken has provided us with a blueprint with which to continue with the engagement and repeat in the future to assess progress. Those that have engaged with us will be crucial in developing ideas into interventions and scaling engagement across the system.

Case study

8. Humber Coast and Vale – "Keep connecting system to more of itself"

Background

A COVID-19 advisory group was set up to work through the pandemic's challenges. The group began with a series of weekly meetings between medical directors. It became evident that the topics stretched beyond COVID-19 to general communication and how to interface outside the system. In response, the Clinical and Professional Group was set up on the back of the COVID-19 advisory group in spring 2020, including representation from ethics, health education, social care, AHP and pharmacy. Due to a disconnect between clinical teams, health and care teams, and the broader executive system, the first main aim of the Clinical and Professional Group was to "connect the system to more of itself".

Our approach

The Clinical and Professional Group works as an 'agile senate' for the system, allowing for fast decision-making on specific issues. The current aim is to further embed this group into the system, with a membership of up to 30 professionals providing a safe and nurturing space to discuss and share learning (Principles 1 and 2 of the CCPL guidance).

The group meets weekly with a structured agenda and fosters free discussions that allow room for positive change. The group provides a system pulse check, and highlights good practice, if anything is going wrong, and changes in approach or direction. The group is currently working on governance structures for evidence development.

Challenges

- Need a good structure in place during transitions over the following months.
- System knowledge: mapping everyone in the ICS will take at least six months.
- Insufficient resources to support CCPL across all the ICS – this is appointed time – with all resources sitting with Clinical Commissioning Group (CCGs) and an employment commitment to shift to ICBs.
- Principle 4: how to shift resources into CCPLs, refill the backlog and provide and support dedicated leadership training and development.
- Resourcing bid uncertainties over the next few years due to insecurity of funding forecasted over the following years (risk to Principle 3).
- Need for clear succession lines since the CCPL principles are bound to relationship building, leadership development and recruiting pipelines.
- Principle 5: this is a transition principle with a longer-term focus on the need for a diverse talent pipeline, bringing together AHPs, health and science, pharmacy, nursing, medical and social care professionals, to promote equity of opportunity in recruitment.
- Room for improvement with wider system engagement, ensuring the proper discussions are held and leaders are linked in with the group.
- Development work is needed on what it entails to engage with the Clinical and Professional Group.
- Lack of administrative support.

Lessons learned

It's important to find out more about local and regional systems (there is a need for the time and space to find out who and what is out there).

Having a link between the Clinical and Professional Group and the chief executives, system engagement, and having the correct representation as part of the group are all essential. We must build up and continue with the momentum of engaged stakeholders.

This transition period will last a few years.

Top tips for other organisations

Know your system – the system needs to be connected to more of itself. Get to know your community and neighbours in the system.

Be inclusive and cast your net wide to engage people from across the system.

Have an open-door policy and share the ICB's vision.

Align leadership with statutory demands.

It is important to take some time/space for reflection.

Try to push new different things whilst maintaining learning behaviours and values.

Offer a positive and safe space to share learning.

It's important to keep the size of the group manageable.

It's important for everyone in the system to feel they have a home in the clinical and care professional directorate and know who they can come to with any queries.

Next steps

- Encourage senior clinical leaders to come together on a regular basis, work on a development plan and start to link more widely into the system.
- Bring in senior clinical sponsorship for the provider collaboratives and to secure clinical leads in six places, focused on the key areas of population health management, local engagement, innovation and research.
- We hope to be able to push more on a proactive approach (focusing on population health management, segmenting cohorts and patients, improving the overall health of the general population) rather than reactionary NHS priorities (elective recovery, system improvement, effectiveness, etc.), ensuring the clinical and care professional directorate is embedded in both approaches.
- Implement an employment commitment for the next nine months to secure clinical working sessions in the system, trying to link everyone in the system undertaking clinical work and ensuring they are connected.
- Focus on the recruitment professional pipeline and what the system looks like as it transitions.
- Prepare to integrate the wider community of pharmacy, dentistry, GPs, and other primary care organisations to join the directorates, offering a regional and national overview on how to support this process and get the system ready.
- Recognise what health and care could mean – a focus on prevention, population management and a fair society.

Case study

9. Cheshire and Merseyside – A method to apply design thinking

Background

The case study outlines the process and methodology used to collaboratively design the Cheshire and Merseyside Clinical and Care Professional Leadership (CCPL) framework, with commissioned support from the Innovation Agency Coaching Academy.

Our approach

Creating this framework is an opportunity to galvanise and coordinate clinical and care professionals and amplify their voices across the ICS. Developing the framework based on established principles provides a focus for collaborative discussions and relationship-building across the region. Objectives include:

1. Comprehensive stakeholder mapping, mobilisation, engagement and co-design.
2. Management and delivery of a crowd-sourcing platform to engage up to 2,000 stakeholders.
3. Delivery of design thinking methodology workshops with core group of diverse leaders.
4. Testing of the framework development with the wider community during iteration process.
5. Drafting and delivery of a framework document that can be shared more widely.

Purpose and membership of design group/workshops

The members of the design group will be representative of our system partners and will attend three full-day workshops to create an inclusive framework. We have now identified clinical and care professionals for this group. Design group members are required to attend all workshops to see the process through. The design group will comprise a minimum of 15 members and a maximum of 25 (although we may raise the upper limit slightly, if necessary, to ensure full representation of the professions involved). The three workshops will be held over the course of two months.

Idea Drop overview and purpose

Idea Drop is an online crowdsourcing platform that allows ideas to be shared, commented on and taken forward in an open and transparent way. It's purpose is to support the development of the Clinical and Care Professional Leadership framework design group work, through allowing a diverse range of voices from across the Cheshire and Merseyside clinical and care community to contribute. It will allow us to:

- Set a series of challenges linked to the five principles that can be responded to by a broad 'crowd' of clinical and care professionals
- Pose questions and challenges from the design group back into the Idea Drop Community
- Feed the ideas and responses from Idea Drop into the design group workshops
- Transparently and openly share the journey and progress that is being made
- Allow all staff to feel that they have been able to contribute to the process and influence the future.

Challenges

- Championing and communicating the requirements of this work by senior leaders.
- Sharing of stakeholder databases between ICB and ICP and Innovation Agency to reach all staff.
- ICB and ICP governance structures and senior leaders established to enable decision-making mapping.
- ICS leadership and communications support and prioritisation of crowdsourcing campaign (i.e. cascading relevant messages to targeted audiences).
- Timely roll-out of crowdsourcing campaign and subsequent workshops is dependent on rapid project initiation and smooth implementation of digital platform.
- Assurance of participant engagement and stakeholder input is a shared undertaking, dependent on transparent communication channels, information flow, and advisory input. Identification of 15 participants who can commit to all three workshops.

Impact measurement

Participant interaction and engagement via crowdsourcing campaign, aligned to metrics developed with platform provider (Idea Drop).

Participant feedback about process and delivery, to include impact statements.

Regular feedback about process and experience gathered from all design team members.

Regular status and summary reports to be checked with project and advisory boards.

The ICS collaborative will be ready to submit a robust, meaningful local plan.

Next steps

- Design group members identified and confirmed.
- Stakeholder map data review and gap analysis (under way).
- Communication plan priorities outlined.
- Recruitment and engagement plan for Idea Drop – wave two of recruitment campaign.
- Idea Drop live to design group and other priority stakeholders with challenges.
- Idea Drop goes live to clinical and care community with challenges activated.
- Initial ideas fed into the design and development group workshops.

Case study

10. Mid and South Essex – The Big Room: networking across the system

Background

The Big Room is a series of events held monthly, with representatives from across the system gathering face to face for networking opportunities. An evening meal is included, with external speakers invited to present on their areas of expertise (e.g., the first talk was given by a Paralympian, the next session will be by a high-performance team expert, talking about the principles of alignment, engagement, influencing, etc.).

Our approach

The idea behind the Big Room (maps to Principle 2) is to bring teams and organisations together who may not usually meet and allow them to socialise whilst intentionally mixing them.

Similar to a Community of Practice (people working as a single voice), the aim is to integrate clinical and care professional leaders and build relationships across the system over food/meals in meetings with loosely educational purposes.

Invitations are shared via the LinkedIn group – MS The Big Room. Membership includes over 60 participants, and the guest list has more than 200 individuals. The venues vary (e.g., hotels, universities), and meetings are held around the centre and south of Essex.

Challenges

- Tricky to get the right people in the room because the people most difficult to access are the ones most needed: the 'room' doesn't exist meaningfully in, for example, the voluntary sector, patient participation groups or social care settings.
- It is challenging for people to attend in person in the evening and commit to subsequent events.
- We need to balance face-to-face sessions (more immersive experience) vs virtual (more accessible).
- It is difficult to explain the aim of the events using the cause and effect model; the aim might seem nebulous to guests.
- It can be challenging to convince people of the value of the networking opportunities and small nudges (e.g., informal career opportunities happening in social environments). This makes it difficult for them to engage.

Impact

Suppose we are working under the assumption that the most important thing in an ICS is to create relationships. In that case, the Big Room offers the opportunity to develop these relationships. It offers a space for people to come together and act as a catalyst to generate opportunities for further work.

How to manage complexity? By breaking the usual rules about thinking and fostering activities that connect people. A measure of success will be how many people from different organisations can attend the events.

Lessons learned and next steps

- Gather more people than the original list – now using personal invites from influencers within the system.
- Work with influencers within the system.
- Venues have been paid for or offered for free. Choose a venue to try and draw in the host, e.g., if a university is hosting the event, this encourages some of their providers and partners to attend the event: 'Inviting the ICS into their territory.'
- Try to mix attendees and get conversations going that wouldn't happen otherwise.
- Move the frequency of the events to a bi-monthly or quarterly basis to allow for service pressures.
- Follow the energy – have conversations with people at the end of events to get feedback (e.g., one attendee suggested starting the event at 7pm so GPs would be able to attend on time).
- Plan to record events so these can be shared widely.
- When managing a complex problem in a complex environment, you need to move away from a traditional cause and effect view. If taking a complexity approach, any serendipity/collision creates an opportunity. Even if using people's time may look inefficient, (Lorenzo butterfly effect), it would be difficult to predict what might result from it. However, if these events are not undertaken, we will never know.

III. Principles in practice

In this final section of case studies, we have identified an opportunity to capture the delivery of services, development of approaches and other ways in which ICSs have been able to match their development plans to the guiding principles. This serves, along with the previous content of the report, to bring attention to, and allow consideration of, practices where clinical and care professional leadership is contributing to impactful delivery of the aims of the ICS.

Case study

11. Bath and North East Somerset, Swindon and Wiltshire – System Leadership Programme

Background

The Bath, Swindon and Wiltshire Leadership Academy (BSW Academy), is an experiment in operating systemically, commissioned by the System-Intelligent Leadership Programme to build system leadership across the ICS and at place (the ICS incorporates three integrated care alliances).

This is a cross-sector, multidisciplinary programme bringing together clinicians, care leaders, leaders in the voluntary sector and other professionals from across the system to learn together how to transform patient outcomes and build a resilient health and care system.

In September 2020, a leadership team was brought together, including nursing, medical and managerial staff, to support multidisciplinary working. The ambition was to create a new Urgent Care team at the Acute Trust, with its own culture and identity, visions, and goals.

A working group was formed with local leaders from across the different organisations with the intention of grappling with some really difficult challenges and realising some of the untapped potential of collaborative working.

Our approach

BSW's System-Intelligent Leadership Programme addresses both the 'inside out' problem of leaders 'making meaning' of complex, intractable issues. At the same time, works with the 'outside in' problem of leading in a changing context whilst building resilient organisations and communities. This is supported by a web-based app, Shiftspace, which provides curated content as well as exercises, journaling and coach feedback based on an individual's reflections about their learning and development.

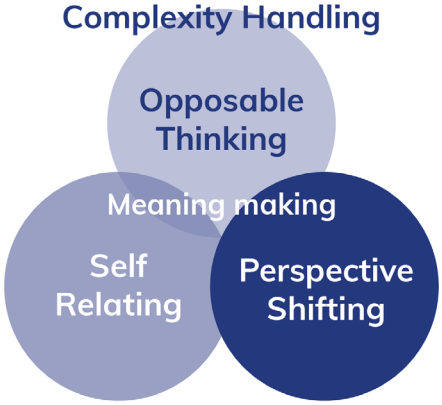
Throughout the programme, this work is complemented by in-person development days with an emphasis on building strong networks between professionals and places, covering the theoretical underpinnings of a systemic and complexity paradigm, complemented by skills for system diagnosis, dialogue skills, intervention design, movement building and adaptive leadership.

This programme creates the conditions for working across traditional boundaries, with the potential for transforming an organisation.

Cross-organisational
Cross-professional
Cross-sector networks

QI Tools

Complexity Handling



Challenges

At the Acute Trust, three teams from three different organisations had been unwillingly pushed together under the banner of integration to create an Urgent Care Service.

There was no sense of team identity, practitioners worked in silos, and nobody felt listened to, resulting in open animosity between the teams.

Staff did not have all the necessary skills to see the full range of patients attending Urgent Care.

The Minor Injury Unit, the Urgent Treatment Centre team (which had previously been owned by a private company), and Bath Extended Medical Service, who were contracted to provide GPs had very different mindset and cultures.

There wasn't enough physical space.

This meant staff were unhappy; with many staff leaving, patients were not receiving the care they deserved and key performance indicators were not being met.

Evidence of impact

A key objective of the programme is to build a cohort of 100 leaders, across place and system, who have engaged in a peer-to-peer developmental experience, developing a shared language and systemic perspective and working collaboratively to solve entrenched problems. Alumni from the programme will be supported to become facilitators of the programme content, and to lead subsequent cohorts of peers, as well as initiating a programme for first-line leaders and managers, deepening and extending a new leadership model for the ICS.

Lessons learned

Shared improvement language and tools

Members of the Acute Trust leadership team and Minor Injury Units were engaged in the programme, bringing together a broad range of tools and shared language, supported by knowledge and experience that could be tapped into via the course network, supporting programme progress.

Cultural environment for change

The skills being developed on the course were able to unlock some of the long-standing challenges both within the team at the Acute Trust and between the various organisations providing Urgent Care: for example, the importance of perspective shifting; the ability to switch between different perspectives in meetings; and having the bravery to call out behaviours being displayed helped to build trust within the Urgent Care team and allowed them to voice their frustrations and be listened to.

Experimenting with change

One thing that helped to solve even the hardest challenges was the open and honest approach to just giving it a go, our 'safe to fail' experiments: "let's try it and if it doesn't work, we can tweak it or try something else." This approach gave the teams confidence to test out new ways of working in a safe and supported way but also gave them the opportunity to design and test it themselves. After a few months, conversations covering controversial and gritty issues, like "of the two IT systems (one from each of the original teams at the Acute Trust), which one should we choose and which one should we lose?" were happening with open discussion and challenge.

Improved relationships

Better listening skills were being employed in meetings which had previously been fraught with defensiveness. Weekly improvement huddles for frontline staff at the Acute Trust, taking place on the shop floor, were initiated and over time, attendance gradually increased. Now the Acute Trust have twice-weekly huddles attended by 10–15 staff members including GPs, consultants, nurses, healthcare assistants, support teams and managerial colleagues. These are well facilitated, and all staff contribute to improvement ideas.

There are now fortnightly system Urgent Care working group meetings and frequent informal visits and conversations between the teams across the various organisations, helping to build trusting relationships. Not everything we try is successful, but we are willing to give stuff a go. We have a clear shared understanding of the purpose of Urgent Care.

Growing as a system leader

Through the System-Intelligent Leadership programme, we have developed and enhanced the personal skills we need to manage ourselves and provide positive support to those around us, helping to bring everyone together as one team. The ability to bounce ideas off each other using a shared improvement language has been incredibly beneficial. For example, the use of multiple cause diagrams has enabled us to bring relatively controversial ideas into our GP service, which has led to a new, more sustainable GP model of care.

Next steps

The skills we have gained through the System-Intelligent Leadership programme have not just developed our own thinking and approach; they have helped us to unlock the potential of our team and start to tackle some really thorny challenges within the wider Urgent Care system.

The tools and techniques we have learned, coupled with an improved culture, multidisciplinary leadership approach, new connections and networks, have created the right environment to support transformational change across our organisations, for the benefit of our staff and our patients.

It takes time
We are almost a year in and are still on our journey. It takes time to change the culture and to build the leadership capabilities to support real transformational change, but staff are definitely beginning to notice a difference.

Case study

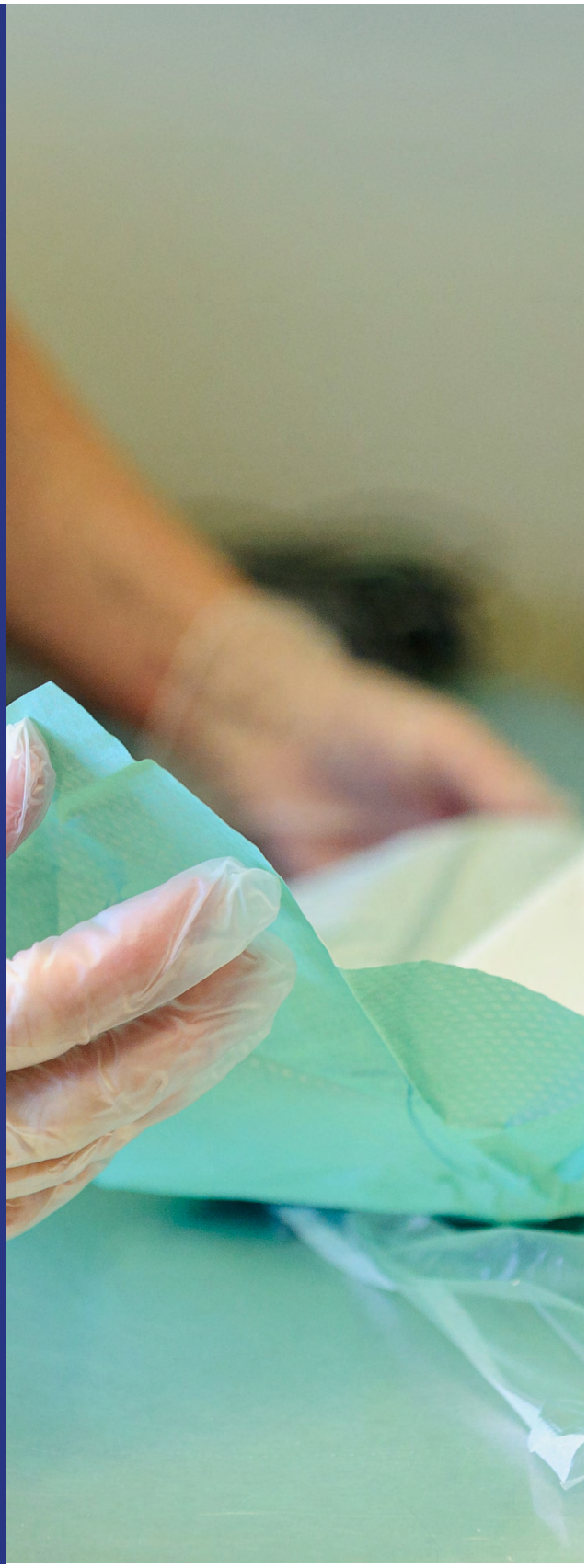
12. Surrey – A system-wide Medicines Safety Committee and Programme

The Medicines Safety Programme (MSP) was developed as part of the wider transformation programme, integrating pharmacy and medicines optimisation within an ICS. The Surrey Heartlands Medicines Safety Committee (MSC) was established to support the MSP work plan and act as a forum to identify, develop and share approaches and solutions to patient safety issues involving medicines. The recruitment of a 'Patient Safety Lead for Medicines' role for the ICS allowed dedicated time to drive forward the programme at pace. The establishment of the system-wide MSC, whose members are multidisciplinary medicines safety leaders and patient partners from across the system, has allowed rapid system-wide progress in several medicines safety areas. The MSP has improved medicines safety and reduced medicines harm, which will have reduced the associated physical, emotional and financial costs to our patients, staff and the wider system.

Prescribing medicines is one of the most common interventions in modern healthcare, but utilising a medicine is a balance between benefits and risks. Medicines have the potential to be a source of serious harm, and errors can occur at any part of the process, from ordering and prescribing to administration. Between 5% and 10% of all hospital admissions are medicines-related. Two-thirds of medicines-related hospital admissions are preventable and could be avoided through positive changes to strengthen medicines systems and processes.

Our approach

- **Vision** – 'to make medicine use safer for the people of Surrey Heartlands' by fostering a culture of continuous improvement, employing collaborative system-wide working.
- **System lead** – a 'Patient Safety Lead for Medicines' for the ICS was recruited to lead the MSP.
- **Forum** – establish a forum in which to lead the programme across the system. This required buy-in from the senior leadership team.
- **Organisational leads** – all ICS organisations were asked to nominate a medicines safety lead/officer to join the ICS-wide Medicines Safety Committee (MSC), committing to a distributed leadership approach.
- **Patient representation** – two patient representatives have been recruited and attend the MSC.
- **Governance** – the wider medicines management governance ensures the MSC is a key part of the ICS's medicines management governance structure.
- **Investigation and identification of key Surrey Heartlands medicines safety themes** through a staff medicines culture survey; Citizens Panel medicines survey; National Reporting and Learning System (NRLS)/Learn From Patient Safety Events (LFPSE) incident data; serious incidents monitoring; safety data dashboards; organisational medicines safety meetings; and aligning with relevant national priorities.



Progress so far

The medicines safety programme work plan is now in its third year. Whilst the MSP has delivered on many specific areas of medicines safety, it is noted that the wider benefits include:

Shared workload of other safety work, allowing faster implementation of improvements.

Practical and emotional support for the Medicines Safety Officers (or equivalent) as a safe team space.

Shared learning about safety with multiple smaller areas of work completed.

Challenges

Delay in progress due to initial recruitment of Patient Safety Lead for Medicines.

Multiple medicines safety priorities.

Necessary reprioritisation of workload.

Relationship-building over Microsoft Teams.

Transition from National Reporting and Learning System (NRLS) to the new incident reporting system Learn From Patient Safety Events (LFPSE) service.

Cancellation of all key meetings.

Secondment of Medicines Safety Lead part-time to a vaccination centre.

Measuring impact

It is always a challenge to put a monetary value on quality improvement and prove prevention of adverse events or admissions. Still, the medicines safety programme has improved medicines safety across multiple high-risk areas. A dashboard developed for each workstream to monitor improvements: for example, the number of patients prescribed methotrexate 10mg (reducing) and the number of patients prescribed high-strength alfentanil in the community (reducing). Incidents and near misses are also reviewed to monitor progress in specific areas. All the medicines safety projects aim to ensure safe prescribing and reduce medicines-related adverse events and acute admissions.

Lessons learned

It was important to understand what was working well and what could be better. Members of the Committee have been asked for feedback through an anonymous survey.

It was essential to keep all members engaged. This was achieved by establishing good relationships with key team members, creating a culture of trust and respect, and having a clearly defined, shared vision with realistic timescales. All members have a voice in a safe environment and we co-design, co-develop and co-deliver the solutions and initiatives. This has helped get regular good attendance at all the meetings, and good engagement with the programme.

Next steps

- The Surrey Heartlands five-year Medicines Safety Strategy and work plan is being finalised.
- Medicines Safety Officer support for the programme will be reviewed.
- A Medicines Safety Committee Stakeholder Reference Group is in development. It will support the co-development of proposals relating to the safety of medicines with the public, patients, carers and other stakeholders. This Group will seek to ensure that programmes under the MSP remit involve a broad range of patient and public experience and seek to support a dialogue that is inclusive.

Case study

13. Derbyshire – Resourcing a Clinical Director for Integration

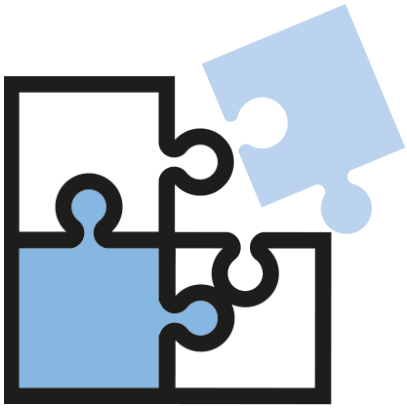
Background

In 2018 the community trust recognised the need to have a dedicated focus on improving working relationships with the local GP community. The Clinical Director for Integration role was created in response to this; a leader in primary care with credibility in both.

- Links to GP leadership such as local medical committees (LMCs) and the emerging Derbyshire GP Alliance.
- Identifying and resolving long-standing issues, such as IT links and flu vaccinations for housebound people.
- Developing the capability of community trust managers who were interacting with GPs in Place and Primary Care Networks (PCNs) to develop constructive collaborative working relationships.

Challenges

- A lack of organisational maturity and insight to recognise that all is not as it could be, and that dedicated resources are needed to make improvements.
- Developing techniques for managing poor behaviours that clinicians and managers sometimes demonstrate (rudeness, arrogance, defensiveness, passivity).
- Developing a compassionate understanding of what is behind the behaviour. What is it that is important to all players? 'Relentless reasonableness'.
- Separating the behaviour from the issue.
- Calling out and tackling the behaviour, but doing it separately from working on the issue.
- How best to empower the health and social care community to work for themselves, rather than being told how to do the work, and how to amplify their voices in the system.



Lessons learned

The Clinical Director of Integration is a key role and resource investment.

It's important to have an informal network that provides a safe space for people to talk.

Commitment from senior leaders is important.

The investment in relationship-building is critical and key to success, modelling a 'relentless reasonableness' mindset.

Skills leadership needs to be distributive and collaborative.

The GP community is a group of providers who need to sit at the system's table, both as a professional and a provider group.

Next steps

The GP Alliance recently appointed a chair/lead and are in the process of aligning their GP structure with workstreams (governance, transformation, etc.) to ensure they have representation of GPs in the right places and the appropriate structures in place to ensure the community's voice is well represented.

Case study

14. Frimley Academy – Creating the conditions for collective leadership

Background

Frimley Academy, launched in 2018, is guided by its whole system mission to nurture collective leadership potential to create healthier communities. The Academy has developed a series of multi-professional, system-orientated, and community place-based leadership development programmes:

- **Frimley 10:100:** a unique dispersed leadership development opportunity for a diverse community cohort of clinical and non-clinical staff. Ten people, across sectors ranging from local government to the community and voluntary sectors, from primary care to social care, were recruited to co-design and lead a virtual programme for 100 people, coming from organisations and communities across the Frimley Integrated Care System (ICS).

- **The 20/20 Leadership Programme:** brings together a cohort of enterprising and innovative leaders from across the whole system: health, care, community, education and voluntary sectors.

- **Wavelength:** brings together digital transformation, clinical, care and non-clinical leaders from across the Frimley ICS.

Frimley Academy's Vision and Strategy
The Academy is:

- Acting as **system-wide convenor:** overseeing the ongoing development of the CCPL framework as Frimley transitions to the new statutory ICB.

- Supporting the delivery of Frimley ICS's strategic EDI ambitions through a range of senior leadership and diverse team development interventions.

- Managing a leadership development campaign plan that delivers an increase of 500% in the access and scale of the Academy's multi-professional, multi-organisational, leadership development.

- Purposely working with organisational partners and with the community to develop a diverse and inclusive **talent pool**.

Our approach

Frimley Academy's aim is to exploit the opportunities of the Academy's semi-independent status, focusing on:

- **Energising leadership and culture change as a catalyst and disruptor** – delivering leadership programmes and extending support into more informal learning spaces: action learning and coaching, community-led and socially orientated.
- **Community leadership development** – focusing on supporting equity and empowering staff to improve outcomes that really matter to their communities.
- **Acting as a conduit** – making social connections, pulling knowledge into the organisation, making sense of it, and sharing it to speed up change.
- **Being a strategic partner** – seeking production opportunities with our partners and communities across the system to increase inclusion leadership accessibility, and equity of opportunities, and maximise the positive impact on more of our people.

The Academy's aims are informed by the CCPL

Principle 1

Generating whole-system CCPL leadership networks to develop a framework based on system learning and system insight.

Principle 2

Nurturing a thriving, compassionate, inclusive leadership culture that reflects the diversity and complexity of the system.

Principle 4

Offering support at all levels of the system to harness the power of people to create leadership and culture change.

The Academy is currently identifying the funding needed to deliver its ambition, with a view of committing circa £500k per year.

Challenges

How to stay agile, responsive and creative when greater numbers of participants are part of the Academy, and the scope of work shifts to system-wide by default.

Meeting the demands that we have heard about throughout extensive stakeholder engagement.

Understanding the most effective way to build relationships in the context of place.

How to promote and progress a more strategic leadership development approach and generally create a more holistic approach to lifelong learning.

Understanding the best ways to build relationships and not to operate out of context of place.

Facing the challenges of operationalising strategy.

How to preserve our critical independence when we change our governance system.

Lessons learned

Being agile and able to respond to the changing needs of systems and the leadership challenge.

Using workshops and alliances to help us to understand the impact of interventions in the delivery of our system priorities and our work.

Reflecting and adapting to ensure a diverse range of colleagues are contributing to the purpose, strategy and programmes of the Academy.

Patience, fortitude and focus on the end state, and the need.

Next steps

The Academy seeks to evolve from its current governance framework, guided by a small but amazing group of people from across the system, into a much more dynamic, diverse and interconnected system model. The Academy aims to do this by creating a multi-layered leadership alliance and leadership conference framework which enlists the lived experience, expertise and insights of an extensive array of stakeholders spanning the wider Frimley Academy leadership network community.

Case study

15. North East London NHS Foundation Trust – Equity, not by accident

Our approach

The NHS People Plan 2020/2021 gives greater emphasis to reducing health inequalities and addressing the disproportionate impact of COVID-19 on people who are black, Asian, and from other ethnic minorities. In response to this, the North East London NHS Foundation Trust (NELFT) set up its Ethnic Minority Network (EMN). Its strategic plan 'Working Together for a Better Tomorrow', aims to change the lived experience of BME staff and to pursue the ideals laid out in the People Plan at a local and national level with the following:

- Leadership and cultural transformation.
- Positive action and practical support.
- Address health inequalities impacting the BME population in NELFT demographics.
- Accountability and assurance.
- Monitoring progress and benchmarking.

The structure of the EMN includes Strategic and Directorate Ambassadors and EMN Champions who provide support in addressing inequalities through working with leaders and teams at different levels. Our aim is to improve the experience of colleagues from ethnic minority backgrounds and ensure that equality, diversity and inclusion is embedded in every strand of the organisation, to achieve better outcomes for the people we serve.

The EMN Ambassadors and Champions:

Work in partnership with teams to raise awareness and address local issues (e.g. domestic violence, knife crime, sickle cell anaemia, poverty, Black Lives Matter, COVID-19 infections, COVID-19 vaccines, etc).

Challenge traditional values, culture and prejudice.

Raise cultural awareness of communities served by the trust.

Identify specific barriers to progression and set plans to eliminate/mitigate these.

Act as a first point of contact for advice and support on issues relating to BME staff and patients.

Remove invisible/artificial barriers.

Impact and lessons learned

Staff satisfaction

The extent to which an organisation values its minority staff is a good barometer of how likely patients are to feel cared for. Increased staff engagement also leads to lower levels of absenteeism, decreased spend on agency staff, and increased organisational efficiency and productivity.

We provide interview skills training to our EMN members to enable them be part of interviewing panels. This helps them become skilled interviewers and gives them confidence as future interviewees, should they apply for other posts.

Outcomes for BME staff:

- Bullying and harassment from the public reduced to 25.5% compared to 33.5% for sector's average.
- Bullying and harassment from colleagues reduced to 21.7%, compared to 24.5% for sector's average.
- Equal opportunities for career progression – 77.7%, compared to 71.8% for sector's average.
- Experiences of discrimination at work – 11.6%, compared to 13.2% for sector's average.
- Equality, diversity and inclusion is scored 9 out of 10.
- Fair organisation score is 84%.
- Support from managers score is 7.5, which is the best score in the sector.
- Staff engagement score has risen to 7.2, which is better than the average.
- 'Thinking of leaving the organisation' score is significantly lower.

As a result of the changes to our recruitment process, the relative likelihood of white applicants being appointed from shortlisting compared to BME applicants being shortlisted improved from 5.1 (2013) to 0.9 (2019), and the percentage of BME staff at senior level has increased:

- Band 8b: from 8.2% (2013) to 28.6% (2019)
- Band 8c: from 2.4% to 38.6% (2019)
- Band 8d: from 7.7% (2013) to 37.5% (2019)
- Very Senior Managers (VSM) 0% (2013) to 23.5% (2019)

Patient Experience

Our third EMN strategy, 'Working Together for a Better Tomorrow: 2020-2025', incorporates several patient experience-related aspirations, including:

- Hearing the patient's voice: use a quality improvement methodology to explore the experience of black men being detained under the Mental Health Act 1983, and how this could be changed.
- Set up an ethnic minority network for patients and service users.
- Deliver culturally competent health promotion and prevention awareness sessions.

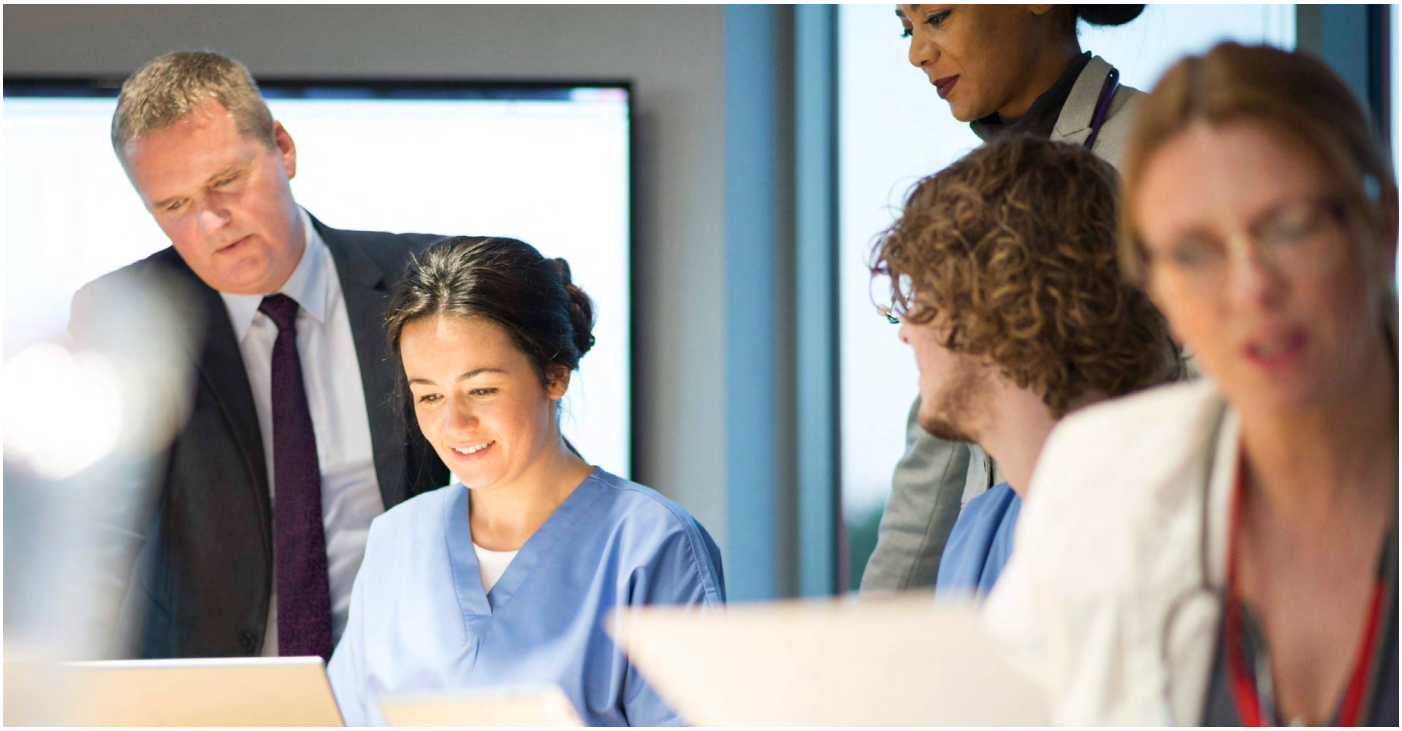
Quality

The ambassadors are involved in the development of policies and processes that reflect a just culture when responding to serious incidents. We hold managers and senior leaders to account for their decision-making, to ensure that staff are not blamed wrongly when a patient safety incident occurs.

Next steps

As the network's structure is aligned to the organisational structure, the EMN strategy objectives are standing agenda items at senior leadership team meetings. Sub-networks were developed due to the vast geographical area served by NELFT, and each directorate holds its EMN sub-network meeting on a monthly basis. General EMN meetings are conducted bi-monthly and network chairs report to the board on a quarterly basis.

Case study



16. Collaborative Newcastle – Place-based leadership

Background

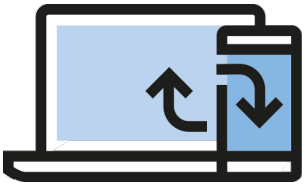
The Collaborative Newcastle System Leadership Development Programme was launched in 2019 to respond to the growing need for senior leaders to work within and across an increasingly complex system. The place-based programme facilitates the development of collaborative relationships and supports innovative approaches to system-wide issues. It is designed, delivered, evaluated, funded and overseen by its five partner organisations, Newcastle Gateshead Clinical Commissioning Group (CCG), Newcastle City Council, the voluntary sector, the Cumbria, Northumberland Tyne and Wear NHS Foundation Trust and the Newcastle upon Tyne Hospitals NHS Foundation Trust. This is an ambitious, unique city-wide partnership, in both scope and scale.

Our approach

Clinical and Care Professional Leadership (CCPL) guidance offers principles for the provision of collaborative clinical and care leadership development. Multi-professional leaders complete a pre-programme engagement survey. A gap analysis highlighted the leadership behaviours for development, recognising the skills required to work effectively in Newcastle. Throughout the programme participants have access to coaching, shadowing and mentoring offers and are encouraged to develop peer support networks. All sessions are interactive and participant-focused, led by experts with experience in, and knowledge of, the challenge's that leaders face, and they provide opportunities to convert learning into practice.

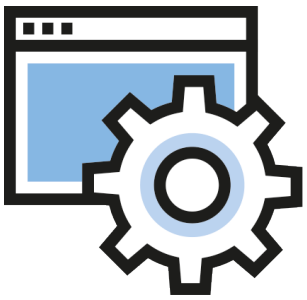
Ownership, engagement and involvement

The programme, including participant cohorts, is led/supported by a Delivery Group and senior stakeholders from partner organisations. Each part of the system has been approached in a way that ensures equity and appropriateness of access to development, and this will be streamlined into a single approach in 2022. Successful participants must have line manager support, and line managers are required to actively engage in the development of their colleague: for example, through joint completion of a "role conversation".



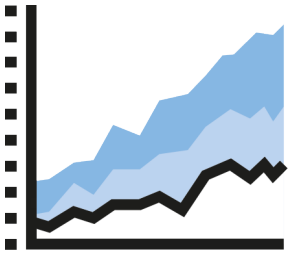
Collaboration and transformation

A key component of the programme is quad work. Quads are formed, with representation from each of the partner organisations, to work collaboratively on an area of shared interest, based on Collaborative Newcastle's health and care priorities. The focus of quad work is on learning, sharing and experimenting rather than on delivering hard outcomes. There are no 'rules' as such for quad work, and this can prove challenging for participants. Having the 'freedom to act', knowing 'there is no right or wrong', no 'fail' element, and no expectation of hard deliverables adds an additional, intended, challenge for participants to work through together.



Sustainability of the programme

The programme is under constant review, ensuring that it supports delivery of Collaborative Newcastle's priorities. Two members of the steering group are also members of the Collaborative Newcastle Delivery Group and participated in the first programme with other colleagues and stakeholders, supporting programme development, delivery and evaluation, and ensuring that content is the 'right fit' to address priorities and the development of system leadership in Newcastle.



Costs

The delivery group is made up of colleagues from the partner organisations, who, apart from the Programme Lead, who is funded by Collaborative Newcastle (hosted by the Newcastle upon Tyne Hospitals NHS Foundation Trust), give their time in kind (for mutual gain). The programme has historically been funded by four of the five partner organisations. The voluntary sector's cost per place has been borne by the other four partners, and the voluntary sector has contributed significantly to the progress of the plan through its membership of the Steering Group.

The cost of the programme prior to COVID-19, based on Programme Lead costs, speakers, materials, resources and venues, was around £75k for two cohorts: however, it is anticipated that costs will reduce for future cohorts, due to the move to a hybrid delivery model.

Challenges

- During the pandemic, the programme moved from face to face to an online environment.
- Delivering and participating in remote/online development programmes was new to the participants, and in large part to the Delivery Group, and has not always been a comfortable fit.
- During COVID-19 we saw an impact on attendance and 'investment of time by participants', and learning from the past two years has been considered fully in the redesign of the programme for 2022.

Measuring impact

An evaluation framework, Kirkpatrick Model L4, is in place, including robust pre-and post-evaluation activity. Return on investment has also been demonstrated. Example testimonials include:

- **Participant:** "Sometimes, management courses, they're just in isolation, just for yourself, and they don't influence the wider sphere you work in. Whereas the potential for these courses is to inform the way organisations are going to function in the future."
- **Collaborative Newcastle Delivery Group:** "We can see tangible links between the collaborative work of the quads and the delivery of Newcastle's strategic priorities."

In 2021, the Delivery Group considered a full evaluation of the programme (based on Kirkpatrick's 4 levels of training evaluation) and made recommendations to move to a hybrid learning model and to focus more on system stewardship as well as leadership. More fundamentally, the decision was taken to move from seeing this as a development programme to seeing it as vehicle for developing system behaviours, which has influenced content and design and led to a rebranding: 'Learning to Lead Together'.

Lessons learned

During the heightened response to the pandemic, the programme's format was adapted. A series of optional, pop-up and lunchtime learning sessions were offered to increase participant engagement, and these were so effective that they have been adopted into the new programme design. Other learnings included:

- The use of online engagement tools to assist engagement in virtual settings and self-directed learning, and to sign post learning and materials and increase levels of engagement.
- Increased time for discussion and increased small group work.
- Protected time for quad work.
- Protected time for networking to strengthen peer support and cross-professional working.
- Reinforcement that quad work is primarily about collaborating, learning and experimenting on a shared area of interest, not delivering hard outcomes.
- Increased focus on a place-based approach to addressing widening inequalities.
- The need to develop accredited coaching capacity.

Next steps

- Increasing the focus on inequalities: for example, looking at inequalities through a Human Learning Systems lens.
- Increasing focus on existing and new threads around: community assets, neighbourhoods, Collaborative Newcastle's partners' role as anchor organisations, primacy of place.
- Extending the learning offer across all levels of place-based professionals in partner organisations.
- Developing a joined-up process for selecting future cohorts based on a single set of criteria.
- Developing a blended (hybrid) delivery model with a mix of virtual and face-to-face sessions, with the ability to flip entirely to virtual delivery should the need arise (COVID-19/ operational pressures).
- Run future cohorts in pairs and in parallel. This will give participants greater flexibility to attend sessions on either programme, which will also increase the opportunity for colleagues to build wider system networks.

Case study

17. Suffolk and North East Essex – One Team

The One Team Professional Development Programme is designed to improve the ability of multi-agency, multi-professional members of integrated teams to work effectively together. It includes four two-day taught modules and workshops with a celebration day. System and line management sponsorship increases the sphere of influence of the programme, ensures participation, and gives a return on investment directly in the work done, as well as indirectly through enhancing leadership capability.

Background

Successful Integrated Care Systems will develop, promote and invest in effective, integrated team-working across the healthcare pathways people have to navigate. Teams that continue to operate in 'tribal' or organisational forms create an inefficiency that cannot be afforded financially, clinically, or socially. The NHS has been used to operating in siloed ways of working to assist payment methods for its providers, which means that its workers have learned to operate in that way too. If we don't invest in helping them change their working practices, both operationally and culturally, the usual way of working will persist, and teams forced to work together will be at risk of fracturing their relationships.

Our approach

Why?

In 2013, the GP leadership of the Ipswich and East Suffolk Clinical Commissioning Group (CCG) wanted to develop not only their own leadership capability but that of the consultant teams they were working with to redesign healthcare pathways. They engaged Hays to assist approximately 30 people to understand the post-2012 system, the importance of clinical leadership, and the importance of clinical leadership extending across the system. This was externally evaluated and found to have merits in developing confidence in decision-making and relationship-building across the primary, community and secondary care sector, which in turn helped participants to enable change.

What next?

One Clinical Community (OCC), and One Team is a training programme for medics, nurses, AHPs and social care practitioners. It introduced practical methods of problem-solving, ensuring that participants learn about the importance of investing in the supply chain from a non-NHS business, and developing a culture that supports professional relationships for better patient outcomes. Workshops have been held on making meetings meaningful, fearless speaking, developing a thinking environment and supporting the right culture in which to work. Embedding system problems into coursework helped them understand the system better, how it works (or does not), and their place in it. It also demonstrated the power of good and accessible data.

Regional Leadership for Integrated Care Fellowship is a course that supports GP clinical fellows in their first five post-Certificate of Completion of Training (CCT) training alongside system-based non-GP clinicians (pharmacy, PAs, AHPs, nurses). Twenty-seven fellows from six systems in the East of England have benefited from this training, which was commissioned by HEE (Health Education England). This demonstrated the transferability of the modules and the programme design it was all delivered virtually.

The programme costs vary according to methodology, with virtual delivery being less expensive than face-to-face delivery. The approximate cost is £2,300/delegate. Delivery requires 2–3 lead presenters and programme support. Support is offered to participants too, and frequently used. Action learning sets usually require 1–2 facilitators.

Challenges

- The greatest challenge is in demonstrating the need to invest in this way. We originally, and repeatedly, used CCG funding for the course fees and asked participating partners to cover the time required by participants.

- Too many partners are not engaged sufficiently: they do not provide enough support to their staff who then get called out of their training at short notice. Sponsoring stands out as a possible way to address this. Active sponsors will follow and promote the people they invest in, and develop their talent pipeline. If we can ensure this is done systematically, the investment then delivers even greater value.

Measuring impact

We have evaluated our OCC and One Team alumni impact longitudinally through independent academic means to see which elements of the programme are valued most and have impacted most people beyond their participation. We are waiting for that evaluation to be published.

We also regularly survey our participants and ask them to write a personal reflective piece at the end to understand what impact the course has had on them, so we can modify the course when required. These evaluation findings have been used to help develop an undergraduate offer in learning about integrated care at the University of Suffolk's Institute of Health and Wellbeing (an MBA in Integrated Care has now emerged). Alumni are participating in research activity and the clinical entrepreneur programme, stating that their participation in the course gave them the confidence to do so.

An alumni network is proposed to continue to build relationships and develop the leadership and innovation that come from feeling confident and effective at work.

Lessons learned

Remain confident about the long-term aims; don't just worry about the short-term challenges.

Play to the strengths of clinical influencing for everyone's gain – ensure we remain focused on equity of access (how else will the Voluntary, Community and Social Enterprise (VCSE) sector and non-NHS organisations participate?).

Create our own team of alumni to influence ongoing investment and development of talent.

Next steps

A business plan so we can ensure that the required investment is made on a long-term basis.

Develop our alumni as the best providers of the course for sustainability.

We hope to see this kind of whole-team development be adopted; it is more effective than training individuals, who may struggle to get traction for change and transformation when they return to their team.

Case study

18. Hereford GP Leadership Team – Working together to provide a single coordinated approach

Prior to March 2020, Herefordshire General Practice had the building blocks in place to provide one collaborative general practice voice. However, COVID-19 expedited this process, as it quickly became clear that we needed a process for effective decision-making to meet the demands of the pandemic.

And so the GP Leadership Team was born, comprising representatives from the GP Federation (Taurus Healthcare), Primary Care Network Clinical Directors, the Clinical Commissioning Group (CCG), Primary Care Lead and Local Medical Committee Secretary. This became the forum for deciding Herefordshire General Practice's initial response to the pandemic, and later spearheaded Herefordshire's highly successful COVID-19 vaccination programme. What's more, it has now become the strategic and operational decision-making forum for Herefordshire General Practice.

Our approach

Very early on, the team recognised that some critical factors would help us to manage whatever lay ahead:

We had to work together to ensure maximum resilience for 24/7 access to a GP for all residents.

We had to have a clear process that supported efficient and timely communication so that all parties worked together as one.

We needed dynamic, clinically led decision-making.

We recognised that we had to invite leaders from the local authority and NHS Trust to our meetings, and we had to attend theirs, so that problems could be shared and resolved quickly and collaboratively.

Together, the nascent leadership team developed a 'six-pillars response' to the pandemic. This included:

- Communication: meetings (via video link), including clinical directors and practice managers, plus the use of GP Teamnet and social media to share critical information.
- Operations support: workforce analysis to ensure sufficient cover was available within general practice throughout the pandemic, including contingency planning to manage staff absences from COVID-19 or other illnesses.
- Governance: development of MOUs with providers and quality assurance matrices.
- Collaboration: link to the voluntary sector through the Talk community, 'silver' and 'gold' command representation.
- Digital: everything was underpinned by state-of-the art digital platforms, enabling remote consultations and joined-up patient records across Herefordshire providers.
- Education: clinical cell (on GP Teamnet) and weekly video education/discussions.

Challenges

- The challenges we faced in the COVID-19 pandemic were unprecedented, certainly in our lifetime. The speed of change required in the early days of the pandemic meant that we had to work together to develop a system what was best for patients, working with our local Healthwatch and local authority's community programmes. We wanted to ensure that GPs remained open, but in a way that was safe for our patients (including the most vulnerable), our staff, the wider community and the NHS.

- As we face the new ICS landscape and significant challenges around the future of general practice, we are convinced that the Herefordshire General Practice Leadership Team will be the most appropriate model for ensuring that a coherent GP voice is always heard. Indeed, it has already attracted the interest of other areas, which are looking to duplicate our innovative approach.

Evaluating impact

There are a number of measurables associated with our approach to the pandemic:

- PCNs were given standardised operating procedures to deliver hub-based care, which subsequently supported a rapid vaccination delivery. One county-wide Super Green clinic for immunosuppressed patients saw over 1,100 patients (at the clinic or via home visits) until shielding ended in July 2020. Its achievements were recognised in the 2020 *Nursing Times* Awards.

- The GP Federation delivered a much-valued Covid Management Service from April 2020 to date. This allowed GPs and healthcare practitioners to refer COVID-19 patients for telephone/video advice and support, thus removing excess pressure on practices. So far, the team has supported nearly 3,000 patients. The Chronic Medication Service (CMS) enabled us to provide the prescriptions for COVID-19 treatment that are now keeping patients out of hospital. The key element was that this service was part of the general practice response.

- Virtual GP services were delivered at scale in a model agreed by the GP Leadership Team, which worked with community teams to support care in people's homes and care homes. This included weekend support to care homes for residents who were unwell or who had a non-emergency, non-COVID-19- related medical need. The service proved invaluable in supporting care homes during COVID-19, with more than 2,200 appointments being provided between April 2020 and July 2021 (when the service ended).

- Workforce pools, training and HR processes were delivered at scale to underpin the resilience of practices and PCNs.

- Business intelligence was collated to ensure we could be clear about our progress, help to identify inequalities, and support practices/PCNs where needed.

- The Herefordshire General Practice Leadership Team provided a source of immense support and encouragement for decision-makers during extremely tough, unprecedented times. With the support of fellow healthcare professionals, we were able to develop local solutions that best protected patients and staff, providing the foundations for general practice to work as a peer in the ICS.

In addition:

- Herefordshire GPs never closed. Thanks to the development of remote technology, we continued to offer patient care via telephone, video or face-to-face consultations.
- Herefordshire benefits from joined-up patient records, including (uniquely in England) in the out-of-hours environment. The use of the Educational Management Information System (EMIS) web platform across healthcare providers meant that all clinicians were able to access patients' records in order to provide joined-up, seamless patient care.
- The establishment of a dedicated COVID-19 information resource (on GP Teamnet) meant that clinicians could always easily access the latest knowledge in a constantly shifting environment and situation of information overload.

Lessons learned

- One voice for general practice is absolutely essential. It enables trusted, rapid decision-making to be made that supports a system response and is unified across general practice.
- Collaborative working with colleagues from across the system (e.g., NHS Trust, local authority, CCG, pharmacy and hospice) enables a joined-up approach to healthcare provision, for the benefit of all residents.
- Information technology is critical for providing up-to-date, reliable and accurate information. It enables clinicians to do the right thing and to make every contact count for every patient.
- Having joined-up patient records (for us, via the EMIS web platform) enables us to work in a way that is location agnostic – i.e. remote consultations can be undertaken by clinicians from any location. This provides greater choice, both for the patient and in terms of our being able to recruit new GPs and healthcare practitioners, particularly to work in the improved access/out-of-hours environment.

The Herefordshire General Practice Leadership Team has become established as the forum for communicating with and understanding the views of Herefordshire General Practice. We already sit on a number of local strategic and operational decision-making bodies, including ICS Executive, One Herefordshire Partnership, and Herefordshire Clinical and Practitioner Forum.

We are constantly hearing of changes coming down the track for general practice. The current Secretary of State has indicated his desire to make radical changes to the way general practice is run, and several consultation documents have already been published.

Next steps

With significant changes on the horizon, coupled with the introduction of ICBs and ICPs in July (assuming the Bill's successful passage through Parliament), it is absolutely critical that GPs' voices are heard. We believe that our Leadership Team model, comprising its representation from PCNs, the GP Federation, CCG and the Local Medical Committee, is the best model to do this, and could be replicated for use elsewhere. Indeed, we have already received enquiries from others who are interested in our approach.

Chapter 3 – Conclusions, and looking ahead

In recognition of the timing of this research, and since many systems are in the very early stages of designing their local plans and frameworks, there is no summary conclusion attached to this report, beyond those in Chapters 1–3. We hope that these chapters have served to describe the themes of the conversations and feedback we have received in a way that effectively captures both the deep complexity of this work and the patterns that are emerging from the data gathered.

It is important to acknowledge, though, that much of what we have heard has been anecdotal, shared with caveats, and/or is in the emerging stages of consideration. We have not included this material.

We have also been told about unfinished or incomplete programmes and pieces of work, and we have been unable to include these. This does not mean that this information is not worth sharing, but it has not found its way into this report. Therefore, as part of our recommendations, we encourage anybody who has a role to play in the implementation of this guidance to continue to seek out colleagues and practices to learn from, and to continue to share openly the ideas and opportunities that will bring local CCPL plans to life, to help transform the delivery of clinical and care professional leadership.

This report discusses several areas that have helped systems so far, including taking part in Communities of Practice (CoPs) and participating in this action research itself to provide avenues for dialogue across different locations. NHS England was seen to have been 'leading by example,' e.g., with its allocation of funding and opportunities for networking and sharing, which were seen to be contributing to a sense of shared experience and "not feeling like you're going through it on your own". Other external forms of support that participants stated have been helpful in managing the change so far included the use of facilitative organisations, a regional action learning sets model, and the Future NHS online collaboration platform. The role of digital platforms to enable knowledge-sharing across areas was cited as having helped so far. One Team is another virtual platform which has enabled multi-agency groups to work more closely, in Ipswich and East Suffolk. Other groups have found independent consultancy useful. For example, the Humber Coast and Vale ICS has been working with Myron Rogers, a leading system thinker and author on system change, focusing on "connecting the system to more of itself". They observed a disconnect between the Integrated Care System Clinical Commissioning Group (CCG) and the Integrated Care System (ICS), and so the group has aimed to follow Myron's guidance and connect the system to more of itself. To do this, the group has formed an 'agile senate' that has allowed quick decisions be made on issues that need addressing.

In terms of looking ahead, areas of further support have included more consultancy and coaching, including emphasising the role of the Human Resources (HR) and Organisational Development (OD) functions in helping to join the dots between different professional roles. Given the time it takes to uncover the more implicit and taken-for-granted dynamics of working cultures, the role of OD and HR was seen by many to be crucial. Indeed, the potential for HR to support cultural transformation as well as recruitment and retention across the landscape of health and care has been emphasised more recently by NHS England. In the findings collated here, the OD function was seen to bring knowledge and insight as close as possible to the needs of both the workforce and those accessing care; emphasising collaboration over competition and opening out leadership identities beyond traditional clinical trajectories.

> *"I think it will need a lot of coaching to get teams to think in another way."*

> *"We need someone outside the system, supporting the system to move forward."*

The development of methods and ideas to encourage people to share good practice, (such as architectures, and terms of reference including; creating a knowledge hub or shared repository for ideas and resources, case studies, and examples that people can draw upon and learn from) has helped to drive progress so far.

Consistently, the impact of small multidisciplinary groups formed to build trust through accountability and visibility has been noted across research streams. These smaller pockets are, in many ways, creating an ideal environment for new collaborations, and are beginning to join up across systems. In complex environments, these small changes have the capacity to scale incrementally, and positive impacts are already being felt in terms of identifying the need to create a shared language, open out existing networks, and symbolically allow leaders to 'hand over the reins' to other professions.

> *"When setting up a task and finish group to develop our ICS framework, it was important to hand over the reins to someone else so it wasn't my thoughts or views on what should come. Asking an AHP to chair the group instead of a doctor or nurse was intended to send a clear [message to] the system that this was different and not the usual type of development work. It required dispersed leadership to enable as many diverse views as possible to come forward, but no matter how broadly we scoped, there was always the concern it wasn't wide enough. It has very much got caught up in CCG closedown work and been confused with contractual changes due to reorganisation. It requires a focus back on 'why' we are doing this – because the old system didn't work and this is a chance to completely change how we lead. As it is a process of change, it requires the usual techniques to allow early adopters and laggards the time to work it through, but against a background of impending organisation change. There needs to be a continuous amount of drive, and using a very experienced facilitator worked really well, as they kept their eye on the finish line."*

There are wider concerns over amplifying retention issues and the ramifications of this for the future workforce, since many senior staff are leaving; this, in some cases, removes the opportunity of mentoring to support junior career progression.

> *"Leadership is for all – that's the culture change we need to install. It isn't training, it is awakening thought processes and values and enabling people to create their own leadership style. Those are the elements we have to release in Cornwall."*

It was acknowledged that it will take some time to disentangle people from their professional clinical boundaries, to think in new ways for themselves and to co-create meaningful, values-based leadership moving forward. This will help to embed the values espoused into everyday working practices, and to "challenge ICSs to demonstrate how they are 'living' the principles". There is, however, an opportunity to integrate these principles from the start of a career in health and care, and to genuinely align the principles into the working lives of staff in the CCPL community.

> *"The work around advanced practice is across four pillars – leadership, education, research and clinical. The element of clinical leadership hasn't been there as a foundation. The new programmes are talking about the four pillars of practice right from graduation, which is reassuring, but there is a lot of confusion between leadership and management, and because there's a focus on amendment it disempowers people to lead rather than empowering them (to be clinical leads in their areas)."*

Final thoughts

Over the course of a few months, we have heard from many NHS staff who are participating in a diverse and open phase of discovery. This has been hugely positive, and we have heard much powerful, contradictory and challenging feedback, and a rich collection of ideas and experiences that we hope readers can learn from. These are our final reflections.

Transformation, the kind that really changes the way we think, work and live, tends to be gradual. The CCPL guidance has been designed to encourage and support this change, and we have sought to draw attention to, and elevate case studies that reflect this, including the voices of those who are leading and participating in exploring the application of the guiding principles.

We have heard that this guidance has provided a stimulus to elevate the voices of professions, institutions and places that may not always have been heard, but that have a critical role in the future of health and care. We have heard about the tensions that surround the nature of the guidance – from those who expect it to act as a blueprint for change, with all the associated 'top-down' measures, targets and assessments that follow, and from those who expect the guidance to be used as the seed from which place-based, context-specific design and development of strategy can be nurtured.

We have heard narratives of hope, and of disappointment. We have listened to stories that describe division and deeply rooted, unsustainable models of clinical and care practice that seem impossible to change, and stories that pulse with the vision and implementation of future-focused partnerships, with genuine collaboration, communication and co-production at their heart. The success of these is measured by the local, small, but deeply powerful results we have seen for communities and patients.

We are also aware that, as we have been gathering the stories and cases that make up this report, others are also addressing and considering issues of leadership, the emerging ICS model, places and communities, and change in the public sector and in health and care – forums, conferences, networks, books, reports and research that seek to promote a vision of what health and care could, or should, reflect are abundant. There are senior leaders being appointed, each with ideas that may or may not reflect those that we have heard. Depending on who you follow on social media, you may be part of an open conversation on clinical and care professional leadership. Practitioners are overloaded with information, yet there is much we have not been able to include in this report. Therefore, we have grounded this report in what we have heard, listening to the people who are doing the work and collecting their experiences and insights.

In the end, we have found that the best way to summarise what we have heard is through this simple idea, which we hope carries strength to those going through this change; the scope of work being shouldered by individuals, teams and systems is demanding, and the institutional challenges being faced are compounded by an environment in which the working conditions do not always support change. And yet there is hope, ambition and opportunity: in some cases we can see the early signs of transformation, inspired by the principles of the CCPL guidance and influenced by the shared agenda around learning from each other. In other systems and cases, we have seen initiatives and practices that may have been around, but at the edges of the system, and are just now becoming more visible because of the way they reflect the principles of this shift in approach, and there are examples where long-standing approaches to co-production, work at place, genuine equality and diversity, collaboration and partnership are central to the way a system delivers effective health and care outcomes for its community, and in these we can sense further changes as this way of working is reinforced and celebrated.

Often, it is not what happens that is important, but what it means. And, as we continue to see the increasingly rich displays of the way in which the CCPL guiding principles are being interpreted and implemented across ICSs, it seems important to recognise and reinforce that, if they are to succeed, attempts to influence a system will always be more powerful when they are part of a shared and collective endeavour. The communities that we have heard about in this report remind us of this, and the stories that we have not shared, equally so. We could finish with a list of fascinating and developing approaches that we have encountered, heard of, read about and participated in, but we hope that this report has inspired colleagues to undertake that process of discovery themselves, with teams and partners and in relationship with their systems, places and neighbourhoods.

We have certainly enjoyed the experience, and we wish all colleagues the very best in this ongoing endeavour.

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Appendix – Our method

A mixed-methods approach was adopted to undertake this research, since this has the ability to provide richer and more robust information whilst triangulating some of the findings. All participants in this research were provided with guarantees regarding confidentiality and anonymity. At all times, research was carried out in a manner which strictly complies with the European Union's General Data Protection Regulation (GDPR) and the UK Data Protection Act (DPA) 2018.

1. Desk research

The initial stage of the project consisted of desk research to fully understand and contextualise the learning report and to guide the formulation of questions and themes for the interviews and focus group sessions.

1.1 SenseMaker

SenseMaker is a distributed ethnographic tool that combines traditional quantitative and qualitative approaches to conducting research activities. It originates in the field of knowledge management and decision making support in complex adaptive environments (Van der Merwe et al., 2019; Mark and Snowden, 2017) and is designed to help uncover the deeper cultural attitudes and factors behind topics and contexts. The tool enables the collection of observational narratives and experiences which are signified at source by the participants themselves against a conceptual framework. The software allows for the visualisation of these patterns across the narrative eco system of a wide and diverse population, whilst also gaining local insight, which can be put to use in locally actionable ways. If we monitor these patterns over time with multiple narrative collections, it allows for real-time feedback of attitudinal change and transformation, and can be a way of doing monitoring as evaluation (RCN, 2021; Guijt, 2016).

1.1 Use the space below to share one example that illustrates your experience of implementing the Clinical and Care Professional Leadership guidance so far, or your experience of working in the ways described by the guidance (even if this work predates it). This could be:

Your first reactions to the guidance.

A story that demonstrates the impact of CCPL.

An experience you have had that captures the opportunities that CCPL and this different way of working represent.

An example that reflects the application of any of the principles in the way that you worked.

A reflection on how you or colleagues feel about the guidance so far.

You are welcome to share something positive, negative, neutral or a combination of the above! What matters is that your personal experience is shared and heard.

To capture the depth of the narratives surrounding the implementation of the guidelines, please use this time to reflect on your experience and try to give as full an example as possible.

After vocalising their experience through this story prompt, participants were shown a series of geometric shapes containing concepts and words designed to reflect potential modulators of their experiences. Some of the core concepts included were: the role of governance, diversity and resources; impact; changes to information sourcing, decision-making and communication styles; where action was focused; areas for improvement; compromises being made; perceptions of risk; decision-making styles; and place versus system focus, among others. All of these follow-up questions related to the context of the story the person had shared, rather than their overall experience.

The process of designing this conceptual framework was originally intended to be opened to include the voices and objectives of those whom the tool was intended to benefit, through stakeholder design workshops. However, due to systems and timeline pressures, this design process was shortened, and the framework was informed by abstracting the 'core concepts' from the main objectives and research questions behind the learning report. Once the initial framework had been designed, testing took place to ensure the right balance of ambiguity/clarity had been achieved in the wording of the questions, and that the language was appropriate for its intended audience.

Any data gained by SenseMaker should ideally be situated in a wider context, so that it can be accurately interpreted. Originally in the method design, SenseMaker focus groups were going to be held in specific regions to look at the data collected in their areas and co-produce contextually relevant recommendations and actions to take forward. Due to lower numbers than expected being captured through the tool (perhaps due to current systems pressures and differing needs from the intended audience in relation to this piece of work), however, the design of these sessions was again adapted to facilitate the sharing of experiences in the workshop itself. Two focus groups were hosted by the Cynefin team, one in the East of England region with ten participants, and another in Cornwall and the Isles of Scilly with six people. Furthermore, an idea generation and mapping exercise taken from Cynefin methods was included as a complementary segment in the other additional ICS focus groups.

Demographics

Between 25 February and 23 March 2022, 20 stories were shared on the SenseMaker site. Of these stories, we have permission from the authors (collected as a variable consent through the SenseMaker site) to share 13 stories word-for-word and anonymously.

We collected twelve narratives from Senior Clinicians, two from strategic leads, one from a programme manager and one from an operational lead. There were four responses from 'other' roles, including one PCN community pharmacist lead, one independent chair and advisor on health and social care, one individual working in Organisational Development and finally a Director at Healthwatch, Telford and Wrekin.

The age of participants reflected the level of experience and seniority in the NHS, with the majority of stories submitted by those aged 45–54 (n=8), followed by 55–64 (n=5), 35–44 (n=4) and one over 65. The sex of those who took part was almost 50:50 women (n=19) to men (n=8), with two n/a responses.

When asked to share information on their ethnic group or background, the majority of participants identified as white (n=15), followed by white and Asian (n=2) and Indian (n=1). Two participants responded n/a to this question.

There was some representation from most regions: eight from participants based in the Midlands, three each from North West, East of England and South West, two from South East and one from North East of Yorkshire.

Finally, participants were asked to describe where the narratives they shared took place, to capture the broad range of settings.

Responses here were diverse, with stories having taken place in community healthcare (n=7), primary care (n=6), social care (n=5), acute settings (n=4), community social care (n=3), residential social care (n=1) and hospice services (n=1). A larger number (n=12) of stories came from 'other' settings. These included: at system level (n=3), at CCG/ICS level (n=3), in a framework design group, in a Higher Education setting and at a MDT meeting.

How people felt about their experiences

Participants were asked to say how they felt about the narratives they shared. Roughly two-thirds of stories were experienced as positive (n=8) or very positive (n=4). Smaller numbers of stories were felt to be negative (n=3) or very negative (n=3), and only two as 'neutral'.

1.2 Semi-structured in-depth interviews and focus groups

The focus groups and interviews centred on five key themes:

- Current strategy and approaches
- Shared learning and best practice (case studies)
- Lessons learned
- Thinking about the future – next steps/ sustainability
- Sensemaking session.

Due to the COVID-19 pandemic and the geographical spread of the focus group meetings, interviews were conducted virtually via Microsoft Teams.

Four mixed focus groups were conducted in partnership with The Cynefin Company and integrating Sensemaking as part of the session, throughout March 2022. Ten participants attended at least one of the four focus group sessions offered, and 14 participants engaged in the two Sensemaking bespoke sessions organised for the groups.

In addition, to write this report, the authors attended over 50 sessions (including interviews, regional working groups, Communities of Practice, meetings, follow-up case studies, etc.) throughout March 2022, with over 100 clinical and care professional leaders engaged in these primary research tasks. We had engagement from all seven regions over the duration of data gathering.

Interviews and focus group findings were analysed using thematic analysis. This research method is employed for “identifying, analysing, organising, describing, and reporting themes found within a data set” (Braun & Clarke, 2006).

Thematic analysis is a useful method for this type of research, as it allowed us to compare different experiences of the ICS implementation guidance on effective clinical and care professional leadership (CCPL), emphasising similarities and differences and providing unexpected insights into participants’ experiences. This method also allowed us to identify best practice, which became the case studies in this shared learning report.

The interviews allowed us to:

Develop and deepen emerging themes.	Develop new lines of enquiry.	Identify best practice, share case studies and develop recommendations/ next steps.

2. SenseMaker regional workshops

Two workshops were held separately with Cornwall and the Isles of Scilly, and the East of England to give a regional/area focus to the conversations. In these workshops, participants were asked to reflect on the CCPL guidance and existing experiences of leadership and to share something that stood out to them. From this, conversations were allowed to unfold naturally to uncover key themes, and participants were asked to share the key messages they would like to see in this report.

2.1 Cornwall and the Isles of Scilly area focus group

What are the key themes for Cornwall and the Isles of Scilly in relation to the CCPL guidance?

(1) There can be disconnects between real-life activity and senior leadership.

This has implications for both present-moment information flow and communication as well as future-thinking recruitment and retention of leaders. Learning how to navigate the politics was seen to be a learning journey in itself, and one that is helped immensely by having good role models and mentors. Clinicians are in need of a strategic space within ICSs to support this dual-facing role to ensure "we hear the genuine voices of people delivering care".

> *"We are having lots of meetings about improving flow but they are not getting into what's happening with the single person and everyone's role in it – the ward nurse, social worker, family, patient. There is a disconnect. Those voices aren't represented."*

(2) There was recognition of a need to interrogate concepts such as 'representation', 'recognition' and 'leadership', and make visible how they are seen from the different clinical professional perspectives.

There are expectations, norms and values around how leadership is valued and developed that differentiate between contexts and roles. One participant working in allied health as a professional lead occupational therapist suggested a good next step would be to map out existing leadership networks, giving individuals a greater understanding of how to make links between these spaces and professions in appropriate ways, as well as helping them to understand what leaders are working on/their priorities, to prevent duplication and encourage collaborative working.

> *"It's not just about representation – it's about forming a bridge between the most senior and junior clinicians. How we listen and advocate for each other. We have good representation of nurses of high level but need improvement in connection. Most senior nurses are so busy in meetings that they can't be present on wards, so there is a real divide, but there's room for improvement in that. We as a system need to support people at a high level. The reset and recharge felt tokenistic – do people see communications?"*

(3) Progression pathways are often emphasised differently depending on role.

This influences whether people feel confident and/or prepared to move into leadership roles. Progression for clinical staff, for example, was often seen to emphasise 'management over leadership', meaning that "talented clinicians are forced down a management route, and not a clinical one." From other perspectives, such as social care or auxiliary nursing, there was a lack of progression opportunities, or these were not available in the same way that they were seen to be for doctor and nurse clinical professionals. One participant in this focus group, said that a focus on clinical leadership should be built in from the start of a career. She had seen positive changes more recently in this regard, but expressed that moving forward (Principle 5) in order to empower leaders, some clarity between management and leadership roles would be required.

> *"The work around advanced practice is across four pillars – leadership, education, research and clinical. People have studied to identify that in practice. That element of clinical leadership hasn't been there as a foundation. The new programmes are starting to talk about the four pillars of practice right from graduation which is reassuring but there is a lot of confusion between leadership and management and because there's a focus on amendment it disempowers people to lead rather than empowers them (to be clinical leads in their areas.)"*

(4) Good-quality representation takes time and training.

Rather than just being a numbers game, one attendee argued, in order for leadership to truly represent doctors, nurses and allied health professionals, it is important to build on what is already there in terms of a trained workforce. One of the participants discussed how doctors had been prioritised for leadership roles. They said that it was positive that this was changing, but the conversation should be about how to prepare and inspire people.

> *"There is a tendency for me to be defensive: as a middle-aged male doctor, I'm no longer flavour of the month. It's been doctor heavy and we need to recognise the effort that's going into getting clinical leadership in the NHS to expand. Clinical leadership has been spearheaded by doctors, but a lot of the talk has been 'it's our turn' (i.e. not doctors) whereas it should be about how to get people interested, trained up, and moving away from their professional allegiance. It's about building on rather than swapping and reconstructing."*

Similarly in allied health, there were examples shared of representative and distributed leadership predating the guidance that could be built upon. The West Integration Board was mentioned for including individuals with GP, housing, and business backgrounds.

> *"I am a member of the West Integration Board with people like Dan Rainbow and Jim Tate, who are GPs by background, and that's a good example of representative leadership – we have housing, business managers and carers on that board. I chair the West Integration Group, and we feed up to the West Integration Board – anyone who works there can go. I'm also the chair of Allied Health Professionals Council. How does the system use that council – you've got a ready-made leadership group there to pose questions?"*

Finally, a distinction was made between 'representation' and 'clinical input'. This includes the importance of clinical representation to ensure that decisions are driven by patient advocacy and from the experience of those with an immediate connection 'on the ground' from different points across the system.

(5) Value-based leadership: send the message that leadership is for all.

Previously the focus has been on developing GPs as leaders and giving them representation on boards "as an easy way to get people who have an understanding of the working system – it did a job but it's a fast track to getting people who have an understanding across the board already". Whilst this was seen to be important for ensuring representation from different roles and contexts, to help paint a richer picture of the landscape of care, the CCPL guidance was also understood to present an opportunity to organise governance structures and leadership around shared values, as opposed to being limited to that which is made visible by role and hierarchy.

> *"To bring in other professions – they need to be exposed, be rooted in core values, with no allegiance to particular professional group."*

> *"Leadership is for all – that's the culture change we need to install. It isn't training, it's awakening the right thought processes and values and enabling people to create their own leadership style. Those are the elements we have to release in Cornwall."*

It was acknowledged that it will take some time to disentangle people from their professional clinical boundaries to think in new ways and co-create meaning and value-based leadership moving forward.

> *"When it comes to morals and values, it's about the care you can provide and supporting people to assume the position, not just be paid for it. It is a strong leader who can occupy a space that has been vacated and actually do something different. Throughout my career (I've been an occupational manager for a long time) – what's the difference that I'm not a clinician but I lead clinical staff – well you listen. When does that change from being a clinician and a leader – when does that change happen and how are you trained for it. Well it used to be there was no training to be a leader. I don't think its about formal education – it's about opening mindsets to say there's a different way of working. Your opinion and leadership skills matter – I fundamentally disagree with mindset of because your that profession, this is how its going to work."*

Key messages for the report from Cornwall and the Isles of Scilly:

"I want Cornwall to move to something multi-professional in it's leadership system. Where are people of different ethnic backgrounds, ages? Do we have real stars at the beginning of their careers who bring energy and enthusiasm?"

"AHPs – like Devon and Dorset – on the board. I want a doctor, nurse and an AHP on the board."

"It's not just about representation; it's about forming a bridge between the most senior and junior clinicians. How we listen and advocate for each other. We have a good representation of nurses of high level but need improvement in connection. Most senior nurses are tied up and can't be present on wards so there is a real divide but there's room for improvement in that. We as a system need to support people at a high level. The reset and recharge felt tokenistic – do people see communications?"

"I think there is a conversation to have about disconnecting CCPL from the notion of hierarchy."

"[On the subject of physicians dominating leadership roles] ... we need anyone who has that aspiration and ability to really contribute to the system and make it accessible/open to anybody."

2.2.1 East of England regional focus group

What are the key themes for the East of England in relation to the CCPL guidance?

(1) There are pockets of every single principle across the system, but it's not joined up, and not all principles are present consistently across the system.

A version of this was expressed by every member at the meeting. Examples of specific programmes or organisations that embodied the principles were given, but people felt that this was not consistent across the ICS.

Examples

- The Leading Beyond Boundaries initiative across the Bedfordshire, Luton and Milton Keynes (BLMK) ICS.
- The stewardship approach (clinical-led, service line approach) to learn how to embed CCPL across the system at Mid and South Essex (MSE).
- The three BLMK CCGs: they mapped all the clinical commissioning leads with HR and Finance colleagues and rates of pay, then had 'difficult conversations' with HR to offer a mean level salary for the transition role they were moving to. The vast majority accepted the new role/rate of pay.
- Currently in Hertfordshire/West Essex there are system quality groups and directors of nursing within that group, but it's a pocket of engagement and these pockets need to be expanded into a system, widening the breadth of engagement from the current CCG medical model.
- In Peterborough/Cambridgeshire there is an Assembly for Clinical Care and Professional Leadership, which has an enormously wide membership range, including local authorities, clinicians from primary/secondary/tertiary care, ophthalmologists, and a smaller executive group that meets more regularly. There are other groups relating to health inequalities that stretch across its system.

(2) Embedding ICS changes in a commitment to addressing health inequalities.

- There was a sense that a cohesive governance structure does not necessarily lead to effective implementation, and concern as to whether moving to ICSs will deliver something that actually makes a difference to the public: "it will mean a year of reorganisation, and can we be assured that patient care will actually improve?".

- In particular, how does the ICS concept address the enormous health inequalities in CCGs (e.g., the ten-year difference in life expectancy between inner-city Peterborough and Cambridge suburbs)?

(3) Broadening the focus from transfer of previous medical/clinical roles to engaging the entire community of clinical and care professionals.

- There are particular concerns about engaging those in secondary and tertiary care and those in the voluntary/social enterprise sector, and creating avenues of communication by adapting more inclusive language.

- Clarity of communication was repeatedly raised as an issue, including a need for a simple way to meaningfully articulate what this programme is about and the outcomes/benefits to the system – an 'elevator pitch' for staff.

- The question of how we move from voices/representation to leadership/decision-making that is trusted by all, i.e. a shift from the 'representation' paradigm to a 'leadership and decision-maker' paradigm (this was raised at the King's Fund round-table with the voluntary sector).

- A key reflection is that currently they are lacking the breadth of engagement that is needed: it was felt there wasn't an issue with voice or ideas being heard at the top, but what was an issue was accountability and action for the ideas being presented.

What are the key enablers?

- Time: the message that this is a five-year strategy is important – creates reassurance and a sense of time to act.
- The voices of people on the ground are needed to help set out how we can redesign to meet people's needs (the Organisational Development OD piece was flagged as an example of this, as was the need for culture change).
- There is a suggestion that the difference between people representing different constituencies and making decisions can be framed using the analogy of parliaments and governments.

What are the key challenges?

- Concern about a change of priorities (e.g., actions not being inclusive in the ICS approach) and that the ICS message of balancing voices will be watered down to appease people.
- Creating consistency by bringing the framework together across different 'tribes' – in particular, identifying leadership cadres and keeping communication effective.
- Preventing the ICS from falling into the trap of considering its different frameworks in isolation. This happens naturally where there are different leaders and they do not communicate with each other.
- A need to be better at understanding each other's position on the integration journey.
- CCPL definition/clarification: CCPL is about decision-making at the right level, not about system leadership.
- Organisational Development and changing culture – bringing knowledge and insight as close as possible to people's needs/care needs. It's not about bringing clinical background alone and restricting your identity to this.

Recommendations moving forward

- Regarding timing, it is very much a 1-, 3- and 5- year strategy, with the detail being fleshed out in Year 1.

- Using Idea Drop to encourage engagement in decisions.

- Trying to use the best approaches across our system – individual, systems and partnership leadership. Focusing on a system- first approach by creating a CCPL group and then letting people create a faculty.

- Additionally, we need to identify a different group of clinical care leads to create a triumvirate; will consult in April and May.

- Developing a 'Memorandum of Understanding' to clarify what will be prioritised in each locality, and the main reason we should try to change 'in the way that is imposed' upon us. There was a sense that mutually agreeing this is useful. This could help to create the case for change.

- There is a general sense that existing pockets of cohesion need to be built into communication/implementation strategies rather than reinventing the wheel.

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