



Improving lives **together**

Norfolk and Waveney Integrated Care System



Building a Shared Vision of Success for Clinical and Care Professional Leadership in Norfolk and Waveney

7th September 2022

Time	Description	Purpose	Who
2.00-2.10	Welcome and introductions:	Everyone feels comfortable and we know who is in the room. Attendees receive permission to spend the time focussing on CCPL and we understand it as a system priority. Everyone knows what to expect from the day	Patricia Hewitt , Chair Norfolk and Waveney ICB Craig Chalmers , Director of Community Social Work, Norfolk County Council
2.10-3.00	Overview of Clinical and Care Professional Leadership nationally and locally	2.10 Background and context of the guidance from a national perspective. 2.25 The N&W CCPL framework. How this has been developed locally and an overview of contents, what the asks of today and people understand the national intentions behind the CCPL guidance and the 'ask' 2.40 Local examples of CCPL in action	Professor Des Breen , National Clinical Advisor & Maria Smith , Senior Programme Lead for Leadership and Learning – NHS England Dr Frankie Swords , Medical Director Dr Mark Lim , Associate Director for Planned Care Tracey Williams Clinical Lead for Health Inequalities, Children Young People & Maternity Tricia D'Orsi Director of Nursing – all Norfolk and Waveney ICB
3.00 – 3.15	Questions and Answers	Open opportunity to reflect on what they've heard and ask questions for clarification	All
3.15 – 3.30	Comfort break		
3.30-4.15	Where are we now and where do we want to get to?	To identify and discuss what is happening already, and for an open discussion on what we want to build on, what we want to change and how. 1. Map current good practise of clinical and care professional leadership 2. Identify challenges and how we want to change the way we do things 3. Decide how we want the clinical and care assembly to work and how it should be composed look like and how it will work	PMO facilitators to support each break out session Feedback in plenary
4.15-4.45	Action planning	People focus in on an action that they can start planning now and think together about how to make it happen 1. What actions can we identify today to kickstart CCPL for us? 2. Look back at our manifesto – does this align with today's discussions or do we need to refine our aims and plans	PMO facilitators to support each break out session Feedback in plenary
4.45-5pm	Summary and close	We summarise the key discussions and agreements of the day. Attendees are invited to share reflections from the day	Dr Frankie Swords , Tricia D'Orsi , Des Breen and Maria Smith



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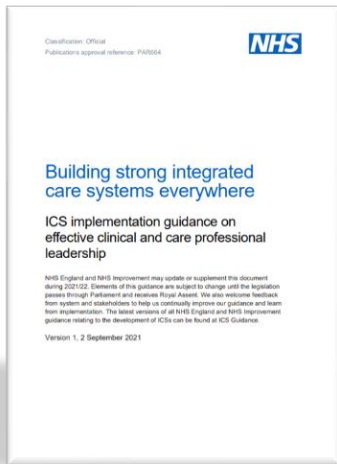
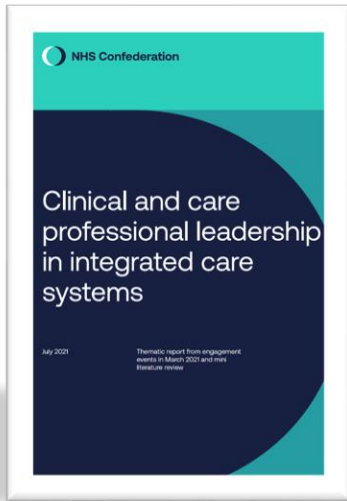


Overview of Clinical and Care Professional Leadership Nationally and Locally

7th September 2022

Developing the Clinical and Care Professional Leadership Guidance

Maria Smith, Senior Programme Lead – Leadership and Learning – System Transformation Team, NHS England
Des Breen, National Clinical Advisor, NHS England



Developing the CCPL Guidance

- A national engagement exercise involving more than 2,000 clinical and care professional leaders working in systems, regions or national roles was undertaken in 2021 to help inform the development of “Building Strong Integrated Care Systems Everywhere: ICS Implementation Guidance on Effective Clinical and Care Professional Leadership” which was published in September 2021.
- Engagement through NHS Confederation through a series of round table discussions, online surveys and specific engagement with interested groups and individuals.
- The intelligence gathered was collated and themed by a Multi professional Steering Group and shaped into 7 guiding principles originally, which were further refined following more feedback, into the 5 principles we see in the guidance.
- The principles are therefore entirely based on the experience and priorities of clinical and care professionals from across the country.

Principle 1 - As Integrated Care Systems, we will ensure that the full range of clinical and professional leaders from a range of diverse backgrounds are integrated into system decision-making at all levels, supporting this with a flow of communications and opportunities for dialogue.

What we heard:

'Connected leadership' is important as it is not possible to have everyone around the table

Clinical groups should be established as **meaningful co-production** of plans during design stages "...need to **avoid a separate 'Clinical Advisory Group'** for every piece of work"

*"We must avoid the **perception that it is just a small number** of senior clinical and professional leaders that are responsible for leading/advising in the ICS.*

Clinical groups can be **viewed in an advisory capacity** only and therefore are **distanced from decision-making** which can make them feel undervalued.

Clinical and care professional **leadership** should **permeate every layer** of the system as part of a distributed leadership model.

Clinicians very much want to **contribute in a meaningful way** to transformational change and decision making.

Why this is important

- Clinical and care professional leadership is **currently not as consistently integrated** across health and care systems as it could be.
- There is a need to **move away from** the propensity to **view clinical leadership roles as representative of their profession or department** to ensure that they are able to contribute fully to whole system agendas
- ICS structures and culture **must allow all layers** of the ICS to collaborate **across organisational boundaries**, from neighbourhood/PCN footprint to Place and system level.

Principle 2 - As Integrated Care Systems, we will nurture a culture that systematically embraces shared learning, supporting its clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities.

What we heard:

The most innovative and transformational change will come from **diversity of leadership** including managers, politicians, community leaders and local citizens/patients.

Culture cannot be forced – it is about **'reinforced practice'** where **collaboration is the norm**, rather than a set of rules or interventions.

*"It is important to recognise that innovation will carry risk and **to allow a degree of failure in learning cultures without punitive measures**"*
Commitment to creating a culture of psychological safety is necessary:

In order to attain the type of culture in which collaborative working could truly thrive, there needs to be **commitment to and investment in time**, as well as processes and conditions which encourage learning.

Culture should be **modelled from the top down**

Clinical and care professionals and managers need to have **access to training in quality improvement techniques** and for the culture to understand and invest in the value of research and evaluation.

Why this is important

- ICS structures and functions facilitate a range of partners to collaborate to improve population health outcomes, but **structures and legislation are not sufficient in isolation**. The **culture of a system is fundamental** to all ICS business.
- In order to create that culture of psychological safety promoted by stakeholders, **a culture of continuous learning** across ICSs and regions is crucial.
- The overall aim of ICSs to improve population health through better collaboration across whole health and care systems offers a **real opportunity to scale and spread good practice of meaningful coproduction** with patients and people who use services across a system.

Principle 3 - As integrated care systems, we will support clinical and care professional leaders throughout the system to be involved and invested in the development and delivery of ICS strategy and planning, with appropriate protected time, reasonable back-fill and infrastructure to carry out this work.

What we heard:

Clinical and care professionals were universal in their appeal for **more sufficient, dedicated and scheduled time** in which to **carry out their system roles**.

Protecting time to build and nurture effective relationships across the system is important. *“[the success of CCPL] will stand and fall on the investment made in establishing and maintaining relationships...creating and protecting space ...in ways that do not require additional effort on top of an already exhausting schedule...”*

The importance of employing organisations supporting collaborative system working by **releasing professionals to engage** is an important enabler.

Practical support is needed, including access to administrative and project/programme management as well as to subject matter expertise such as finance colleagues.

Clinical and care professionals **need access to shared data and analytics** including population health data but also access to data analyst colleagues and public health experts to support in interpreting the data and to build confidence in using the data for themselves going forward.

Why this is important

- Many clinical and care professionals have taken on **system roles in addition** to already busy and pressured day jobs often constituting **significant extra workload and sometimes lacking full understanding of the ask or support required to deliver**.
- ICS establishment provides an opportunity to ensure that **additional responsibilities** accepted by clinical and care professionals in systems are **formally acknowledged and supported** in order that their expertise, knowledge and skills are utilised in a way which properly **demonstrates their value and contributes to effective partnership working at each layer of the system**, informed by the knowledge and experience of those delivering frontline services.

Principle 4 - As Integrated Care Systems, we will create a support offer for clinical and care professional leaders at all levels of the system, which enables them to learn and develop alongside non-clinical leaders (including managers, local authority, voluntary sector colleagues) providing training and development opportunities that recognise the different kind of leadership skills required when working effectively across organisational and professional boundaries and at the different levels of the system (particularly at place)

What we heard:

Additional development support should be designed to **supplement and complement existing leaders' skillset** so that the system and population can continue to **benefit from the wealth of knowledge and experience** they already bring.

It is important that **leaders are clear about leadership competencies** at different levels of the ICS infrastructure.

Role modelling from senior system leaders is key alongside a culture of **compassionate and inclusive leadership** and a compelling vision and purpose, clearly communicated across all levels of the system.

Systems already have many leaders with a **vast array of knowledge, skills and experience**, many of whom continue to have direct patient contact which offers a **unique opportunity to bring together the system strategic view and the reality on the frontline.**

There's a need for **place-based leadership development** where clinical and care professionals **come together with non-clinical professionals to learn together**

Why this is important

- The shift from organisational leadership to systems leadership will require an accompanying **shift in the skills and capabilities** required by clinical and care professionals in system leadership roles.
- It is crucial that **existing skills and knowledge** in the system are **not de-valued** but rather builds upon this to **develop leadership at and between the different system layers**, each with the skillset required for their particular system roles.
- Leaders will need to feel **comfortable and confident in influencing across organisational boundaries** and will need to be willing and able to work with others in tackling complex problems in a collaborative way.

Principle 5 - As Integrated Care Systems, we will adopt a transparent approach to identifying and recruiting leaders which promotes equity of opportunity, and creates a professionally and demographically diverse talent pipeline which reflects the community we serve and ensures that appointments are based on ability and skillset to perform the intended function.

What we heard:

In some cases there is an under-representation of some professional groups in system leadership, which is a **missed opportunity for systems to engage the champions, enthusiasts, innovators and influencers** who are **key to driving transformation**

Under-representation of some groups is a real **risk** that their **skills, expertise and capabilities would be lost** from system leadership

To redress the balance ICSs should focus more on the roles that need to be carried out to ensure they **recruit the right people with the right skills and knowledge at the right time.**

Some ICS roles where specific 'system' time is allocated are having a positive impact. Will need to ensure that there are **fair, transparent and equitable recruitment practices** that underpin this approach and ways of working which enables a **shift form organisational sovereignty** where partner organisations are willing to give up staff time to undertake these roles.

Systems leadership is seen as a pursuit for clinical and care professionals in the latter part of their careers. There is an **opportunity** for systems to **identify and harness the potential for people earlier** in their careers and **involving them in system level leadership much earlier.**

Why these are important

- The **lack of diversity in senior ICS leadership** roles is apparent and the legislative changes provide an **incredibly important opportunity to address this..**
- There is also strong evidence that **diverse teams are more innovative, creative** and are associated with **higher staff morale and wellbeing, performance and patient experience.** Clinical and care professional leaders should reflect this and be able to **respond to the demographic makeup of their local population and wider workforce...**
- Only by having **open fair and equitable ways of identifying current and future leaders** will **inclusion and diversity** in clinical and care professional leadership be achieved in ICSs.

Summary of the Five Principles

<p>1 Integrating clinical and care professionals in decision-making at every level of the ICS</p>	<p>2 Creating a culture of shared learning, collaboration & innovation, working alongside patients & communities</p>	<p>3 Ensuring clinical and care professionals have appropriate resources to carry out their system roles</p>	<p>4 Dedicated leadership development and the opportunity for clinical and non-clinical professionals to learn together</p>	<p>5 Identifying, recruiting and developing a pipeline of clinical and care professional system leaders</p>
<p>Distributed Leadership Model</p> <p>Clinical leaders at all layers of the Integrated Care System have a voice and a mechanism to influence ICS Decision making</p> <p>Robust communications and governance structures to support this</p>	<p>A culture of Psychological Safety across the system to share ideas and innovate</p> <p>Collaborative working across the system enabling clinical and care professionals to share learning and experiences to inform effective integrated care and more responsive services</p> <p>System thinking as the norm and coproduction (including with public) at the heart of transformation</p>	<p>Clinical and care professional leaders have the appropriate time, infrastructure and permission to effectively lead in their area of the system and across the system through a distributed leadership model.</p> <p>Clinical and care professionals have access to the necessary data and to subject matter expert colleagues such as analysts, finance etc, in order to inform decision making</p>	<p>Learning and development opportunities for leaders across the system enabling clinical and non-clinical colleagues to learn together and from each other</p> <p>Leadership skills development programme that is fit for purpose looking to the future of ICSs and the skills required for system leadership</p> <p>Strong and effective offer at place</p>	<p>Mechanisms to identify and develop future leaders earlier in their career</p> <p>Leadership that demographically reflects the communities it serves</p> <p>Transparent recruitment systems based on skills and attributes required for system leadership</p> <p>Professionally agnostic job descriptions, focussing on skills and attributes rather than speciality or registration wherever possible.</p>



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Norfolk and Waveney Framework and Plan: Clinical and Care Professional Leadership

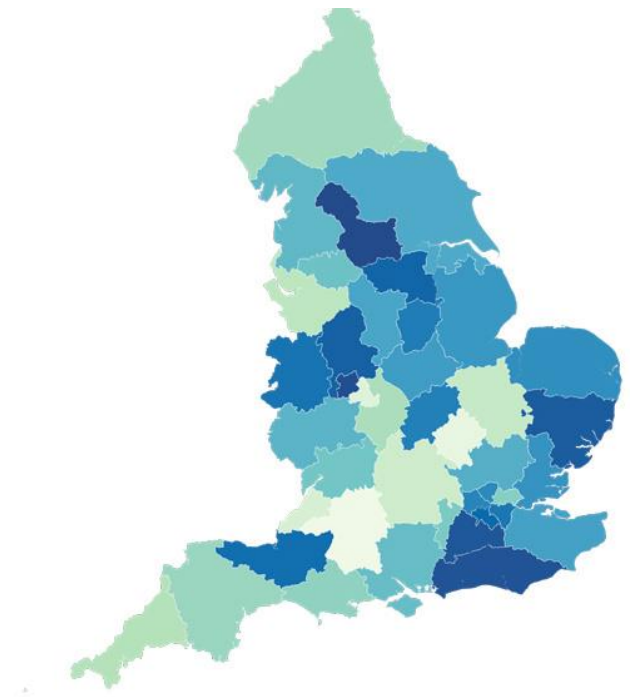
September 2022

Introduction

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

They exist to achieve four aims:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.



Map: The 42 integrated care systems in England

Introduction

Norfolk and Waveney ICS Goals:



To make sure that people can live as **healthy** a life as possible.



To make sure that you only have to tell your story **once**.



To make Norfolk and Waveney the best place to work in **health and care**.

The Norfolk and Waveney story so far

- Workshop for 103 clinical and care professionals held November 2021 led by Mark Lim and workforce team
- NHS Leadership Academy funding provided to CCG to commission Mike Farrah to support leadership training. Agreed through an existing CCG meeting: the clinical care transformation group
- Aims of Mike Farrah work shared and draft framework developed through CCTG and separate meetings facilitated by Mark Lim and workforce team March to June 2022
- These masterclasses are open to all and due to start 27 September 2022
- Draft Framework developed using outputs of these meetings by interim DoN, submitted to NHSEI June 2022
- MD and DoN for ICB in post for 1 July 2022, MD appointed SRO for CCP leadership

The Norfolk and Waveney story so far

- Feedback received from National Team on Framework July 2022 highlighting requirement to sustainably resource plan, requesting more detail on how the CCPL vision will be implemented, how CCPs will drive decision making at place and neighbourhood, how EDI will be demonstrated and reflect the diversity of the communities served and detail on the approach to support a variety of professions entering multi-professional roles including care and non-medical professionals
- Framework further revised by MD in light of national feedback, best practise from other systems, meeting with buddy ICS: Mid and South Essex July 2022
- Extensive engagement with CCTG membership, PCN CDs July 2022,
- 3 open CCPL sessions led by MD (~45 attendees from primary care, acute, community and MH trusts, social care, NCC, public health and VCSE sector) to refine plans July/August 2022.
- CCPL Manifesto shared with Provider collaborative CiC 8.8.22
- Workshop to formally launch CCPL programme and refine plans agreed August 22 – today!
Programme director to lead implementation aiming to join September 22 – March 23

November Workshop outputs

The initial workshop was held on 9th November 2021 and was attended by 103 participants from across the health, care and voluntary sector.

Fully inclusive
– ensuring
diversity seen
as important.

Active
engagement
of grassroots
clinicians felt
to be
important.

Some
participants
felt there was
a risk it could
be dominated
by 'health'.

Some
participants felt
the language
could be
alienating e.g.,
clinician is used
in some areas,
practitioners in
others.

Important
to link with
education
and HEIs.

Welcome the
opportunity to
work together
& collaborate.

NHS
Futures
Space.

Blended
roles

Our commitments

As an ICS, we commit to working in line with the national expectations and principles.

We know that there are amazing people who have been doing amazing things across N&W already. We want to build on these foundations. We want to build a **permissive culture of Quality Improvement**, sharing learning, collaboration and innovation for CCPs to work together in. We want to support them to use a common language, common data, and a common QI methodology, to support them to innovate and continuously measure and improve the services we provide.

We also want to **build the CCP voice** into every decision that we make as an ICB and to ensure that we include CCP roles into all of our structures and at every level including Place.

We also want to build, broaden and **strengthen our current CCP leadership community** with a series of events from September, to bring them together, to ensure a common understanding of our system and aims.

Our CCP Manifesto

The Norfolk & Waveney CCP framework vision is to put CCP leadership at the heart of our discussions at every level of our system so that it becomes integral to our culture and how we work together.

1 The ICB tangibly commits to a clinical and care professional empowerment culture (as defined by the two national expectations and 5 core principles).

2 The ICB will identify resources to support this CCP framework and undertake a baseline survey and then periodic surveys over time to measure the initial and subsequent achievement of these principles.

3 The ICB will review its decision-making structures to ensure that there is clear accountability of where, how and by whom decisions are made. We will also build CCP leadership / representation into every decision making body including at neighbourhood and place.

4 The ICB will establish a formal CCP Assembly (CCPA). This will be recruited through open competition and reflect the diversity of our CCP community (including by profession, band and organization). The assembly will review and advise on all ICB decisions affecting care, becoming a diverse sounding board for the ICB to sense check its ideas and decisions with. This will provide a coherent and effective CCP voice in shaping ICS strategy and resourcing. This will include experts by experience and research/academic representation and support the MD & ND. This will replace the previous CCTG

5 The ICB will also establish a much smaller Clinical and Care Professional Council. It will lead the coproduction of the CCP framework and strategy, support the ongoing programme of training and OD for CCPs and subsequently, act as guardian of the empowerment culture we wish to create, and underpin the work and responsibilities of the ICB MD and ND.

Our CCP Manifesto

The Norfolk & Waveney CCP framework vision is to put CCP leadership at the heart of our discussions at every level of our system so that it becomes integral to our culture and how we work together.

6 - The ICB will also continue to have specialist clinical advisory roles to lead on specific areas such as cancer and diabetes, but these will be recruited in line with this framework reflecting the national principals.

7 - The ICB will invest in short, medium and long term O/D and education to secure the commitment of all CCPs. This will start with a series of masterclasses from September 22. Further work will be overseen by the ICB CCP Council, to develop a pipeline of appropriately trained future system leaders who understand the system and what we are trying to achieve and how.

8 -- The ICB Quality Management team will develop a rolling series of open educational events, to empower all CCPs to use a common QI approach. The ICB evaluation hub will support CCPs to develop appropriate evaluations before trying new things, and the QM and PMO team will provide practical support with those evaluations - to supercharge innovation to improve our services.

9 -The ICB and the CCP Council will work with primary care and practice leadership professionals to keep extending the reach of our CCP community (including AHPs, Pharmacists, Dental and Ophthalmic practitioners, social workers, carers, behaviour specialists and sensory experts), and to regularly review this framework to ensure it remains inclusive and fit for purpose.

10 - The ICB commit to using a clinical prioritisation process for resource allocation that fully involves CCPs, patients and the population, and allows the ICS to maximise health outcomes and reduce health inequalities within our available resources.

Next Steps

Stage 1


Workshop Launch
Sept 2022

- Launch workshop for existing and aspiring CCPs
- Facilitated by national care and clinical leads
- Attendees invited from across multiple professions and sectors
- Aim to demonstrate what CCPL means, why it is important, what it can do for us and our population and to agree some key aspects to work on

Understand our baseline
and appoint our CCP
Assembly and council

- Appoint a programme director to lead implementation
- Map out current meetings/ forums
- Map out all current CCPL roles, diversity and responsibilities
- SurveyMonkey to benchmark current understanding and engagement
- Appointment of CCP Assembly and council

September 2022 – December 2022



Next steps

Stage 2

Develop a culture of collaboration and innovation

- Series of initial masterclasses open to all CCPLs
- Understand what other training and QI support is available across all providers in ICS
- Develop long term standardized QM approach and rolling programme of training events with existing PMO, quality faculty and ICB evaluation hub to build on what we have already
- Develop a suite of metrics to support prioritization of clinical and care projects and resources
- Share what we are doing: Newsletter, webpage, NHS Futures resources?

CCPL roles and leadership development programme
Sept – Nov 2022

- Develop leadership charter
- Review roles and responsibilities of existing ICB leadership roles
- Work with HEIs to develop a training portfolio – inclusive of all organisations, roles and levels to support long term OD and leadership development

January to March 2023



Embedding CCPL long term

Stage 3

Governance

- Ensure CCP inclusion on all decision making bodies of ICB at system and place level
- Ongoing formal engagement with CCP Assembly to support their roles and prior to decision making meetings
- Align CCP council to ICS governance structures in both health and care to ensure ongoing leadership of the framework is baked into ICB.

Support

- Write business case to build permanent team to support the MD and DoN to implement CCPL framework long term as needed
- Recruitment – including dedicated leadership time for CCPA members and other leaders

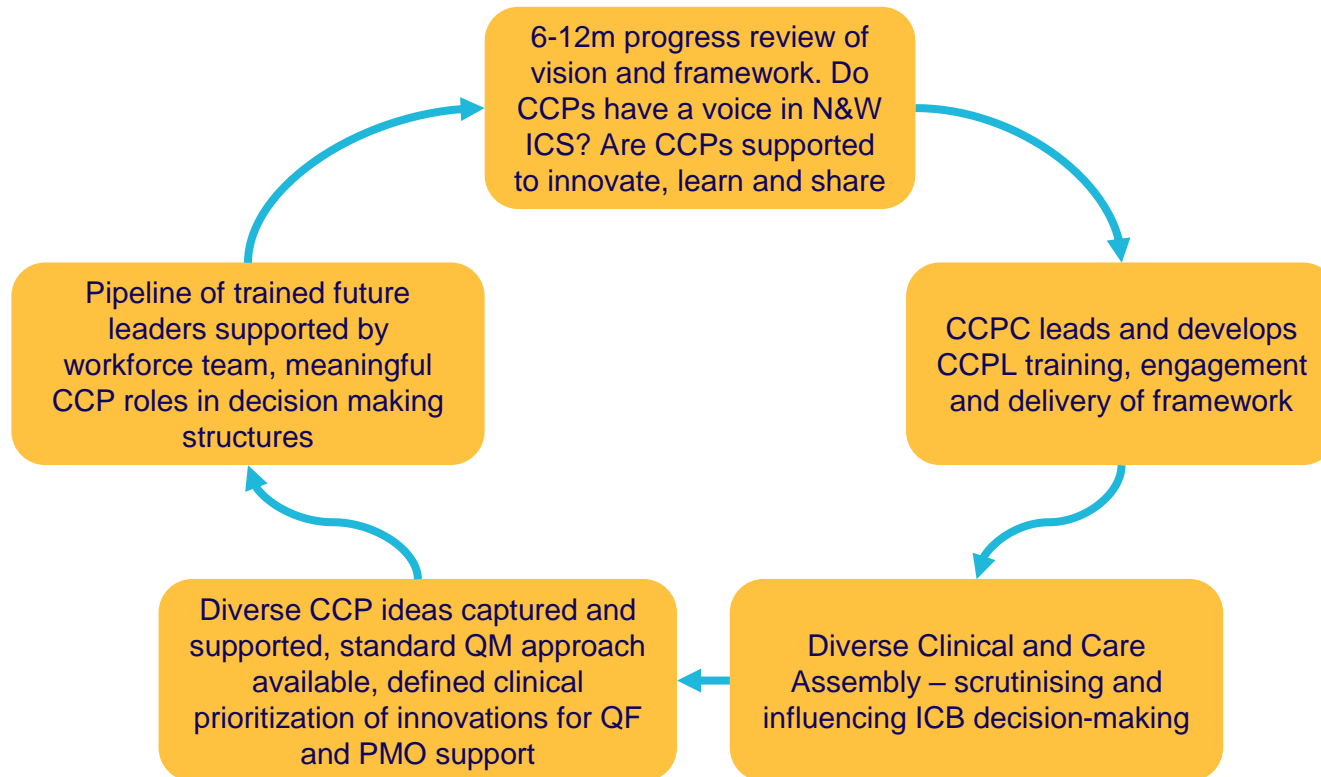
Measurement

- Repeat CCP survey 6-12 monthly to measure understanding, engagement and impact of CCPL framework
- Ongoing review of Framework with CCPC annually – is it still relevant and fit for purpose

March 2023 onwards



Continuous Improvement



Risks and challenges to Implementation of CCP Vision

Risk/ Challenge	Mitigation/ actions
<p>Insufficient funding & time for CCP leadership leading to lack of engagement and lost opportunity to harness CCP innovation in our ICS</p>	<ul style="list-style-type: none"> • Robust planning, external support, learning from others • CCPEG to lead on framework implementation to maximise utility • Early engagement with CEOs and senior management team to communicate importance of programme • Business case for long term support as required
<p>CCPA and CCPEG may not reflect the diversity of our CCPs (including social care leaders) and population and so we may miss opportunities to innovate for all</p>	<ul style="list-style-type: none"> • Equality Impact Assessment on CCPEG to establish the diversity of people needed for CCPA (including roles, banding, organisations, gender, ethnicity we need to be reflected in the assembly) • Inclusive recruitment for all new roles • Former LDG leads to assist identification of first cohort of CCPLs • Robust engagement across organisations
<p>Limited access to data and appropriate training may affect ability to develop informed plans and development of priorities</p>	<ul style="list-style-type: none"> • Data and BI resource review with ICB Exec lead • Work with research evaluation hub and PMO to build QM approach • Work with digital team to develop dashboard • Look at use of apps and other digital tools not reliant on ICS IT system



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Any
Questions



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Pause





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Opportunity to:

1. Map current good practise of clinical and care professional leadership
2. Identify challenges and how we want to change the way we do things
3. Decide how we want the clinical and care assembly to work and how it should be composed look like and how it will work

Where are we now?



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Planning a way forward



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thanks for
joining us!

Reflections and Close