Improving lives **together**

Norfolk and Waveney Integrated Care System

Clinical and Care Professional Leadership Survey Feedback

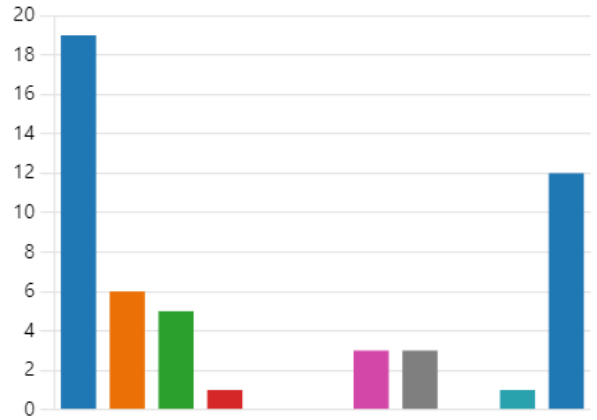
November 2023

N=50

1. Indicate which clinical or care profession you currently work within?

More Details

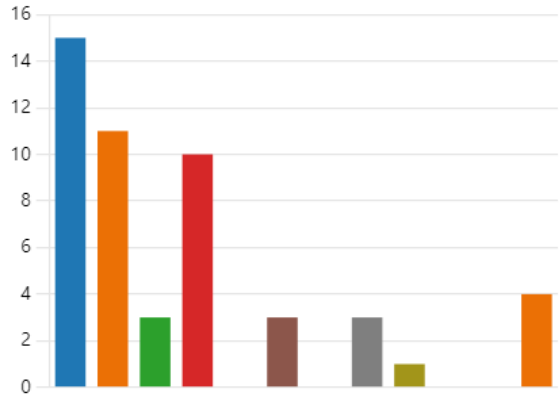
Medicine	19
Nursing	6
Pharmacy	5
Social work	1
Dentistry	0
Optometry	0
Physiotherapy	3
Occupational Therapy	3
Paramedic	0
Advanced Nursing Practice	1
Other	12



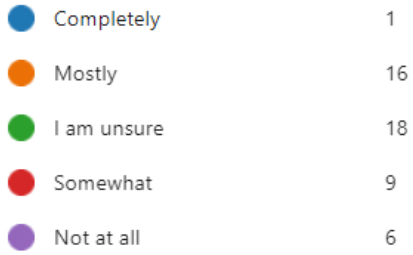
2. What is your work setting

More Details

Acute Hospital Trust	15
Community Health Sector	11
Mental Health/Learning disabilit...	3
General Practice	10
Local Government	0
Social Care	3
Voluntary Sector	0
Primary Care - Community, Phar...	3
Community Pharmacy	1
Dentistry	0
Optometry	0
Other	4



3 and 4. How well does clinical and care professional (CCP) leadership in your organisation reflect the diversity of the communities it serves? How could this be improved?



Talent Management and Peer Support:
- **Cultural Change:** Gradual improvements driven by cultural change.
- **WDES and WRES Failings:** Tackling Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) failings.

Inclusive Leadership and Board Representation:
- **Community Empowerment:** Pushing decision-making power into communities.
- **Clinical Representation:** Advocating for more clinical, including Allied Health Professionals (AHP), representation on boards.
- **Leadership Promotion:** Promoting hardworking individuals leading teams at the frontline.

Community Engagement and Communication:
- **Staff Networks Utilization:** Utilizing staff networks for diverse perspectives.
- **Anonymous Surveys:** Conducting anonymous staff surveys for valuable insights.
- **Improved Communication:** Enhancing communication with communities unaware of available services.

Administrative Support and Diversity Training:
- **Reduced Administrative Burden:** Providing more administrative support for clinical leaders.
- **Bias Training:** Offering training to address conscious and unconscious biases.

Professional Leads and Leadership Recognition:
- **Recognition of Professions:** Recognizing and utilizing underrepresented professions.
- **Visibility:** Ensuring professional leads are well-known among staff.

Systematic Review and Integration:
- **Leadership Opportunities:** Increasing awareness of opportunities for clinical leadership.
- **Working Groups:** Establishing working groups to promote diversity, equity, and inclusion.

Learning Disabilities and Protected Time:
- **Acknowledging Learning Disabilities:** Acknowledging learning disabilities as a significant cohort.

Recruitment Information and Cultural Diversity:
- **Inclusive Recruitment:** Evaluating recruitment information for inclusivity.
- **Cultural Diversity Consideration:** Considering the cultural diversity of the local population in organizational practices and leadership.

through talent management programmes , peer support and mentoring
Addressing Health inequalities and wellbeing issues among staff, addressing WDES and WRES failings
gradually driven by cultural change
https://www.kingsfund.org.uk/sites/default/files/2018-07/Leadership_in_todays_NHS.pdf
Pushing more decision power into communities
more clinical including AHP representation on board
Promote those who work hard strive and truly work leading teams at the front line.
Our Trust has networks for different types of diversity which staff can join. Our staff and their families are also patients within our ICS. They often have invaluable insights into our systems, but it can be challenging to raise this as it can impact on their reputations and highlight their vulnerabilities. It might be helpful to anonymously survey staff about their experience as service users.
We need to offer opportunities. Currently leadership positions can be held for many years with minimal review of quality and outputs.
Less medical colleagues / GP domination
Engaging local communities more directly in career development
outreaching to communities who are not aware of our services , those whose first language is not English, those who have other communication barriers, those who live remotely, elderly , vulnerable communites.
It appears to be general practice heavy, which I am pleased about as a GP but I wonder if acute trusts and other professions are happy with this.
Great start and Andy is trying to improve attendance from non medics and AHPs which will be great
pay for backfill, go out and find people - many clinicians do not consider themselves leaders
more admin support for clinical leaderships to support them to be able to lead and not spend so much time on the admin
I do not feel I know the CCP well enough to comment
ensure staff know what this is
We do not have a professional lead of occupational therapy and thus feel my profession is under utilised or recognised.
More clinics in remote areas to cater for ageing population in NN who don't drive
by having a constant review process in place, more MDT working to improve the service user experience and aid communication too
Needs more time to bed in
Could widen culturally diversity in group or ensure all topics include Equality and Diversity lens.
Beginning the discussion is a good start - continuing and broadening its reach going forward
Remove all kinds of conscious and unconscious bias
I don't think diversity is the problem in medical leadership. I am not sure about nursing and admin structures.
increased awareness of opportunities to take part in clinical leadership across the system
Our leadership figures are probably more diverse thatn the communities they serve.
Involve some less well paid personnel in management
By getting improve integration among all the teams and Health care professionals to accept and have great advocacy for diversity.
More of these working groups
Norfolk is not a highly divers area!
the community served is an aging population, which is predominately hetrosexual and white ethnicity. The leadership in the organisation is typically more diverse in sexuality, race, and there is a balance of genders.
more AHP staff and leadership
Don't ignore those of us who came into the NHS many years ago for waht we could give to it - not what we could get from it. If you hold traditional moral values & are not a member of the 'diverse' communities then it feels as though you are not valued, listened to & are certainly not respected. In all things big & small it should be the best person for the job/task not the ones who just fill the diversity remit.
Greater integration/ joint working between professional groups
An acknowledgement that Learning Disabilities is a cohort of people in the Norfolk and Waveney system.
We need to really improve how we work in parthnership with people with learning disabilites to guide us
Support needs to be in place for colleagues to participate in these activities. Protected time and option of flexible working for people who have other caring responsibilities at home.
I am unsure as I don't really know who provides our clinical leadership above team level and how they may be able to reflect learning disability which is my area of practice?
Being aware of how diversity does compare to the local population
Recruitment information

5. How can we ensure the full range of CCP leaders from diverse backgrounds are integrated into system decision-making at all levels across our system?

CEO and Chair Buy-In:

- **Engagement from Top Leadership:** Acknowledge the need for CEO and Chair support for diversity and inclusion efforts.
- **Commitment to Diversity:** Ensure a commitment from top leadership to prioritize diversity in decision-making.

Engagement with Lower Banded Staff:

- **Inclusive Leadership Roles:** Engage lower banded staff for diverse leadership opportunities.
- **Full-Time AHP Lead:** Establish full-time substantive AHP leadership roles (e.g., Band 8d or 9) within the system.

Stakeholder Engagement:

- **Actively Encourage Diversity:** Encourage leadership development and talent from diverse backgrounds, including socioeconomic factors.
- **Decision-Making by Clinicians:** Increase clinician involvement in decision-making to enhance engagement.

Transparent Recruitment and Visibility:

- **Background Cross-Referencing:** Actively check and cross-reference backgrounds in leadership roles.
- **Transparent Selection Process:** Ensure a well-advertised and competitive selection process for leadership roles.
- **Visibility and Communication:** Increase visibility of existing staff in leadership roles and improve communication about role expectations.

Equal Opportunity and Flexibility:

- **Equal Opportunity for Professions:** Provide equal opportunities for all professions.
- **Flexible Working:** Support flexibility for staff to undertake leadership roles around clinical care.

Mentorship and Guidance:

- **Backfill Support:** Support leadership roles with pay for backfill.
- **Mentorship Programs:** Establish mentorship and guidance programs for aspiring leaders.

Clinically Led Decision-Making:

- **Clinically Led Decisions:** Ensure decisions are clinically led and focused on delivering the best care.
- **Use of Examples:** Utilise examples from more mature ICBs to guide decision-making in N&W.

Representation and Inclusion:

- **Representing Diverse Backgrounds:** Encourage leaders to represent or seek representation from diverse backgrounds.
- **Support for Diverse Leaders:** Appoint, support, and develop leaders from diverse backgrounds.

Inclusive recruitment Practices:

- **Individual Outreach:** Personally ask individuals to apply for leadership posts or secondments.

Investment in Development and Equal Opportunities:

- **Development of AHPs:** Invest in the development of AHPs, particularly in advanced practitioner posts.
- **Meritocracy and Lived Experiences:** Emphasize meritocracy and consider lived experiences as a starting point for equal opportunities.

Neurodiversity and Accessibility:

- **Accessible Interview Process:** Address barriers for individuals with neurodiversity in the interview process.
- **Awareness and Understanding:** Promote understanding and awareness of neurodiversity in leadership roles.

as above. also needs CEO and Chair buy in
You would have to engage with lower banded staff as that is where all the diverse leadership is found. Having a substantive full time AHP lead would also be a start- other systems have full time band 8d or 9 roles.
stakholder engagement
Actively encourage leadership development and talent from diverse background including and beyond protected characteristics for exam socioeconomic
Gain more engagement by giving more decision making to clinicians, not just giving them a chance to contribute
actively check and cross reference backgrounds that we have in leadership v other roles
Engage
Be gair and equitable.
Being involved in system decision making is helpful but time consuming. I think the most challenging aspect of consulting, collaborating and integrating is the time investment. Highlighting the importance of this and prioritising the time to do so would be helpful.
Suggest limit term to allow multiple team members have the opportunity to lead.
Equal opportunities for all professions and that most nurses are woman - we have a patriarchal hierarchal ICS
Conscious recruitment
hard to answer, you can but ask for a diverse representation. Maybe trying to advertise that the systems need the engagement from all staff. Maybe approach the networks- diversity inclusion.
Ensure that those within the roles are reflective of the diverse workforce they represent in terms of professional background, ethnicity, gender etc
Flexibility to undertake work around clinical care
pay for backfill
mentorship and guidance
Ensure a well-advertised and competitive selection process.
more visibility of existing staff, communication so staff know what is involved which would encourage people to apply to the roles
Professional lead roles for each profession are within each organisation, or are shared across providers in the ICS.
equal opportunity given to all staff to get involved and attend higher level meetings etc
better working together better sharing of information equals better comms
Ensure that decisions are clinically led and focussed on delivering best care, using examples from other areas where ICBs are more mature. There is a tendency in N&W to do what we have always done
Community Champions/Leaders to be involved or appraised of direction/plans.
Diversity needs to become the norm rather than something that must be striven for
To encourage leaders to represent or seek representation for diverse backgrounds when making decisions
Appoint and support develop leaders from diverse back grounds
Working on team feedback. It doesn't matter who is leading, as long as leader listens to team and takes team feedback on board.
The system needs to better support the development of place where they can be heard and feel they can make a difference
ask them individually to apply for the posts or secondments
More opportunities to be part of the conversation on pathways and service developement, feedback routes open to all
Include people in basic jobs in management paying them extra to do both. the problem goes both ways, the only way that nurses can get promotion in pay is to come out of clinical work into management - this means that all of the good clinical nurses leave the profession and become managers for which they are not trained - lose, lose
By inclusion and representation .
Good communication
I think this may be in place with equal opportunities legislation
the interview process is a barrier to some people with neurodiversity, and decisions on appointing people to leadership roles are heavily influenced by the ability of someone to 'perform' in a snapshot.
Investment in development of AHPs, when services grow. AHP advanced practitioner posts.
make sure it is relevant to all groups within the system - what are the boundaries of the system?
As above, employing self adocates to have a voice around system decision making
Protected time and option of flexible working. The process to support ICS and external leadership activities as a doctor is complex due to fixed job plans and such activity is often taken in own time.
That's too broad a question for me to begin to think about too deeply. Meritocracy and lived experiences as a starting point?
Making people aware of the opportunities to do so.
often CCP leaders are not involved generally - this needs to change and would then include leaders from diverse backgrounds already in post.

6. Where is this done well? Give an example if possible. Are there anyways this could be improved?

Chief AHP Role and Representation:

- **Full-Time Chief AHP Role:** Express a need for a full-time Chief AHP role within the ICB for better representation.
- **Inclusion in Provider Organizations:** Advocate for Chief AHP roles in provider organizations to enhance representation.

Clinical Voice and Influence:

- **Clinical Forums at Locality Level:** Acknowledge success at the locality level with clinical forums but note challenges in having the clinical voice heard at the system level.
- **Influential Assembly:** Highlight the importance of assemblies for sense-checking and influencing changes, particularly in clinical strategy and prioritization.

Clinical Advisor Roles and Fair Selection:

- **Fair Selection Process:** Appreciate a fair selection process for clinical advisor roles, allowing emergent leaders a fair chance.

Leadership Programs and Communication:

- **Kings Leadership Program Success:** Highlight the success of the Kings Leadership Program in facilitating communication, discussion, and issue tackling.
- **Regular Programs Across Trust and ICB:** Suggest the need for regular leadership programs across the trust and ICB for better communication.

Diversity in Leadership:

- **Representation from Diverse Backgrounds:** Cite examples from the corporate world (Google, Amazon, Apple) to emphasize the importance of leaders from diverse backgrounds.
- **Perceived Lack of Diversity Impact:** Address perceptions among medical colleagues that they are not being listened to, possibly due to a perceived lack of diversity.

Pharmacy Services and Community Representation:

- **Diversity in Pharmacy Management:** Highlight the diversity in community pharmacy management but note a lack of reflection in commissioning and contracting decisions.
- **Utilizing Diverse Perspectives:** Advocate for finding ways to utilize the diverse experience and perspective of community pharmacy managers.

Retaining Clinical and Management Roles:

- **Balancing Clinical Work and Management:** Emphasize the importance of retaining individuals in both clinical work and management roles.

Success Stories and Personal Experiences:

- **Personal Example of Success:** Share personal success stories, such as experiences from Pakistan and the acceptance of diverse backgrounds leading to improved outcomes.
- **Recognizing Successes:** Highlight successful initiatives like the Florence Nightingale Foundation.

Community Integration and Local Recruitment:

- **Fragmented Community Integration:** Note challenges in effectively integrating at the community level, with fragmented systems.
- **Local Recruitment:** Suggest the importance of recruiting locally for better community engagement.

Benchmarking and Comparative Analysis:

- **Lack of Comparative Analysis:** Express uncertainty about effective benchmarking and comparative analysis in the given context

In our mental health trust
Full time Chief AHP role for the ICB would be great- 67% of ICB's now have a role in place across England and also Chief AHP roles in provider organisations
NextGen GP do this well
Done well at locality level with small projects but clinical voice not heard at system level
the assembly sense checks and influences suggested changes eg clinical strategy, JFP, prioritisation matrix
Distrute Minutes of ICS meetings
Not seen any evidence of it in this Trust.
Clinician lead forums based on clinical need. for example the Complex cases meeting between clinicians at the Colman Centre for Specialist Rehabilitation and the Norfolk and Suffolk Foundation Trust.
Other ICS a and ICBs some examples in Yorkshire
i am not sure it is. do we have examples of systems that have representation from the whole population of Norfolk ? if we have representation is it proportional to the population ?
When the clinical advisor roles were reappointed, it felt like a fair selection process and emergent leaders were given a fair chance to apply rather than the same individuals who had done the job before.
CCPA works very wel to provide a wide range of opinions and options on clinical related concerns
Kings leadership programme really helped not just from the information but the ability to regularly meet up and communicate/ discuss issues and how to tackle them plus get to know other people across the trust- this would be good as a regular programme both across trust but also now across the ICB
NCHC do this well.
good email communication
MDT working with social work practitioner's, OT's and other agencies like GCL in the case of drug misuse
I have not seen any decisions which have been truly innovative or which have really changed the status quo. An example would be respiratory prescribing where the views of a small number of individuals have stalled progress
Google, Amazon, Apple have leaders from diverse back grounds who focus on development and well being
Medical colleagues feel they are not being listened to on few issues but that's not because of lack of diversity.
Was done very well in the 5 CCG's prior to the reorganisations
Community Pharmacy Managers, supervisors and owners tend to be more diverse than the populations they serve, however this is not reflected in the commissioning/contracting of pharmacy services, we need to find a way to utilise this experience and perspective.
Ensure that people remain in clinical work and management as doctors do
I believe my own practice is the best example, I came from Pakistan with a background of women health, I was accepted and encouraged to continue area of my interest, I did my fellowship in personalised care for menopause, so as I mentioned by inclusion and representation of a diverse group in any medical or non medical set up can improve the overall output and results.
Florence nightingale foundation
I am not sure we do it effectively in a community sense, as currently our 'integration' at community level is very fragmented. When we talk about 'place' are we referring to PCN, or District Council? We have parallel systems.
Recruit locally. The current medical director has been in post for more than 5 years and was recruited internally.

7. What are your current CCP leadership groups/committees/networks/councils/communities of practice?

Clinical Representation in Committees:
- Emphasis on clinical representation in various committees across trusts.

AHP Involvement at Different Levels:
- AHP involvement in the ICB assembly, ICB AHP council, and faculty.
- Presence at place and ICB levels.

Community and Assembly Participation:
- Participation in CCP assembly.
- Involvement in local communities, such as Health Equity, Trailblazer Deprivation Fellowship, Leadership Peer Support, NextGen GP communities.

Local Team Meetings:
- Regular team meetings where different teams come together to solve problems at a local level.

Changes in Activities Over the Decade:
- Notable changes in activities over the past decade, leading to the loss of certain reflective practices like journal clubs, research forums, ethics committees, and service development forums.
- **Opportunities and Gaps in Primary Care:**
- Limited opportunities for primary care nurses compared to trusts and those on Agenda for Change.

Participation in Various Networks and Groups:
- Involvement in regional Communities of Practice (CoPs), team leads, ethics committees, diversity networks, and AHP assemblies.

Representation in Oversight and Management Groups:
- Representation in various oversight groups like Population Health Management Oversight Group and executive nursing groups for ICB.

Involvement in Leadership and Management Structures:
- Participation in leadership meetings at the PCN and ICB levels.
- Representation in trust boards, divisional directors, and management structures.

Lack of Specific CCP Leadership Group:
- Lack of a named CCP leadership group in some trusts.

Networking Through Professional Boards:
- Networking through various program boards, regional events, and LPC (Local Pharmaceutical Committee).

Specialty and Condition-Specific Involvement:
- Participation in groups related to specific specialties (e.g., gynaecology, rheumatology, menopause ambassador).

AHP Council Focus on Workforce Development:
- AHP Council's focus on workforce development rather than clinical needs

all trust committees have clinical representation
AHP ICB assembly, ICB AHP council and faculty
norfolk
Health Equity community | Trailblazer deprivation fellowship community | Leadership peer support community | NextGen GP community
At place and ICB level
CCP assembly
Local only
Team meetings where across teams come together to solve problems like " fequent problematic attenders " to UCR.
In the past decade, to increase productivity, we have lost many of the activities we would regularly access where we had a chance to reflect on practice, for example Journal clubs, research forums, ethics committees and service development forums. Some alternatives have been developed, such as special interest groups (SIGs) and complex case discussion meetings.
Minimal opportunity as only a few have these opportunities.
None for primary care nurses compared to trusts and those on agenda for change
A selection of regional CoPs
team lead, ethics committee, we care diversity network. N & W AHP assembly.
departmental & Primary care network
Population health management oversight group, I also sit on the Local Medical Committee
NHPDF / CCPA / executive nursing group for ICB
practice, PCN, CD locality group, GYW partnership group
none
N/A
I don't know
PCN / ICB leadership meetings
We don;t have any and have no repesentation at wider AHP forums.
none
Not good CQC Registered Managers want to engage with others but it can feel like walking up hill at times sadly
I a the clinical adviser for respiratory within the ICB
Speciality Professional Networks, Trust Lead groups.
Intra ICB and links with PCN peers and colleagues
The Hospital Trust board. Divisional directors and managers. PALS.
There is no named CCP leadership group in our trust, i am not aware if there is one
Clinical lead forum
North Place
gp partner/clinical director/trainer/uea tutor
Integrated Therapies Manager, Professional Leads, & Team Leaders
Networking through various programme boards, regional events, the LPC
Gynaecology
Menopause Ambassador
Multiple safeguarding groups
unsure what this means
North Place, NCH&C, ICS networks for catheter care, East of England continence network, Queens Nursing Institute, District Nursing community of practice
dont know more information from leads
There are groups but I am unsure of their purpose
Regional Rheumatology meetings, struggle to have meaningful and sustained AHP presence.
No idea
none
Leadership lunch and learn
Not sure.
I simply do not know and so will find it hard to answer 8 or 9
None specifically, although planning this in 2024
AHP Council but only for workforce development not clinical needs. Personally attend National and Local professional leads meetings in my clinical field but often my attendance of this is challenged.

8.How effective are your current CCP leadership groups/committees/networks?

8. How effective are your current CCP leadership groups/committees/networks?

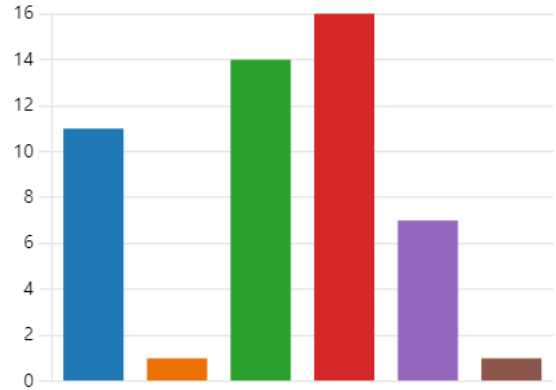
More Details

Very effective	3
Somewhat effective	20
Neither effective nor ineffective	16
Somewhat ineffective	8
Very ineffective	3

9. How often are you able to share learning with your system?

More Details

Never	11
Yearly	1
Quarterly	14
Monthly	16
Weekly	7
Daily	1



10. What are they and how could they be improved?

Strengthening System Patient Safety:
- Suggested improvement through strengthening the system patient safety specialist group, LFD, patient experience teams, nursing and medical directors' meetings.

Ad Hoc and Clinician-Driven Learning:
- Mention of learning sessions being ad hoc and based on individual clinician interest and motivation, addressing the needs identified by clinicians.

Challenges with Staffing and Time:
- Challenges with staffing recruitment to avoid constant meeting cancellations and allow sufficient time for effective management.
- Difficulty in fitting learning activities into daily demands.

Communication Channels for Sharing Learning:
- Use of regular email updates on patient safety.
- Sharing through emails within the immediate team and monthly team meetings.
- Sharing practice, such as NICE guidance, in network group meetings.

Orientation and Relationship Building:
- Recognition of the need for good orientation and opportunities for new ICB members to build relationships with team members.

Meetings and Forums for Learning:
- Participation in regular face-to-face meetings, bimonthly to quarterly meetings, and weekly meetings with the trust executive team.
- Involvement in regional Communities of Practice (CoPs) and fortnightly exec group.
- Monthly staff meetings and team meetings.

Clinical Reference Group and Program Boards:
- Suggestion of having a clinical reference group for major long-term conditions (LTCs) and the involvement in program boards.

Limited Influence on Pathways:
- Difficulty in influencing pathways of care when multiple organizations are involved.

Need for Clarity and Understanding:
- Mention of the need for better understanding of certain questions or terms in the survey.

It can be done through strengthening the system patient safety specialist group, Lfd, patient experience teams, Nursing and Medical directors meeting. Place based learning would also benefit
i feel empowered to share and speak up
Link up regionally
Better staffing recruitment to ensure meeti gs are not constantly cancelled and enough time is spared to manage not just fill staffing crisis gaps all the time.
They are ad hoc and based on individual clinician interest and motivation. However, this is good because it addresses the needs the clinicians themselves have identified.
regular email updates on patient safety.
Only in practice
Regional CoPs and fortnightly exec group
can share with the immediate team with emails , can share monthly in larger team meetings, sharing practice such as NICE guidance with all team. Shared learning in the network group meetings.
As only 1 session a week it is difficult to learn on how learning can be shared more widely (i.e. beyond my immediate circle) so that successful projects or processes are adopted more widely
New ICB members need good orientation and opportunity to build relationship with team members
what are what? did you pilot this questionnaire before sending?
time for it. difficult to fit in with day to day demands
We have bimonthly to quartlerly f2f meetings
ok as they are
I can see such better service delivery within the community a saving on repeated re admissions but some will not engage so its frankly not joined up
Is it worth having a call clinical reference group for major LTCs?
Programme Boards
There is a meeting in the hospital weekly with Trust executive team, all staff are invited to contribute.
I haven't had a chance to share any learning, although noted emails with shared learning from senior leadership
previous CCG clinical forum worked very well for exchange of learning both to and from the system
Monthly Staff meetings, Monthly Team meetings
verbal feedback to a small group, need to look at publishing wider learnings for all to access.
On our weekly meetings.
Variable
There is some sort of annual questionniare I think - and there are meetings we are invited to attend
redesign of the clinical capacity model to release clinicians to be able to attend essential and effective peer experience sessions
more clinical staff invited to meetings, not just B7 and above
Difficult as unsure whet learning is referred to. It it needs to be shared then at a service level it is. Little shared across the Trust
East Anglian Rheumatology Society. Need AHPs to attend.
Understand what it is in the first instance
They are NCC centric, and I expect in ICB they are health centric.
LD nursing away days, clinical governance and NHS east of England forums for LD nursing and regional round table events
We keep improving in our service but challenging to influence pathway of care when other organisations involved.
SLT local meetings and clinical governance

11.How do you think collaboration and innovation within the ICB and with system partners could be improved?

Cultural Shift for Collaboration:
- Emphasis on creating a culture of collaboration across management structures
- Focused on everyone understanding how to effectively collaborate, inclusive leadership, building trust, and developing positive attitudes toward risk.

Progress and Improvement:
- Recognition that progress is occurring at a reasonable pace.
- Suggestion for an organizational map and structured time for joint working.

Long-term Funding Commitments and Behaviour Demonstration:
- Advocacy for long-term funding commitments and demonstrating collaboration through behaviour.

Transparent Sharing, Open Communication, and Engagement:
- Encouragement for more sharing, especially when things are not working, to facilitate improvement.
- Call for equal opportunities, more frequent collaborative meetings, and open lines of communication.

Visibility and Understanding of ICB:
- Concerns about the ICB not being well-sold to staff, especially those on the ground.
- Suggested actions to make the ICB more visible and comprehensible to clinicians.

Conflict of Interests and Innovation Stifling:
- Concerns about conflicts of interest stifling innovation and collaboration.
- Call for flexibility in meetings, focusing on non-medics, and supporting clinical care.

Diverse Representation and Wider Engagement:
- Advocacy for diverse representation and engaging a wider range of practicing clinicians.
- Suggestions for regular meet-ups to build relationships and ensure open lines of communication.

Streamlined Collaboration and Clear Objectives:
- Calls for more streamlined collaboration, clearer purpose, and action to avoid overlapping objectives.

Communication and Achievements at the Local Level:
- Emphasis on more communication and local achievements for patient care improvement.

Understanding Local Demographics:
- Recognition of the importance of understanding local demographics for services that extend beyond the immediate area.

Encouraging Learning Across Boundaries:
- Encouragement for learning across organizational boundaries and facilitating collaborations at lower levels, involving frontline staff.

ICB Visibility and Collaboration with Partners:
- Suggestions for making the ICB more visible, collaborating with system partners, and connecting new ICB posts with NHS trusts for increased staff contacts.

Time for Networking and Building Relationships:
- Emphasis on allocating time away from the "day job" for networking events and relationship building.

Tailored Pathways for Professional Groups:
- Frustration expressed about being grouped into generic AHP categories and a call for more specific pathways for each clinical professional group.

through creating the culture of collaboration across management structures including senior to middle management levels
everyone understanding how to effectively collaborate. inclusive leadership, building trust, culture and values, developing positive attitudes to risk
Organisational map and more structure time for joint working
By long term funding commitments and demonstration through behaviour
more sharing particularly when things are not working to make sure we stop them
Willingness to Engage
More frequent meetings that are collaborative where everyone can contribute and participate freely and equally.
Creating a directory of clinical networks and forums for clinicians to access when needed might be helpful. Many clinicians may not know certain forums exist and therefore may not know support is available to them..
ICB to mandate clinical groups.
Equal opportunities
Further joined up working. Clear processes and governance structures. Methods to share innovation
The ICB needs to have a face, members of the ICB most likely meet with place directors to discuss news in their PLACE. the clinicians on the ground only know the ICB as something that has come along and will guide and enforce care across Norfolk. I do not think the ICB has been sold to staff in a good way. We are having more meetings intertrust at a community partner level but the staff on the ground are not involved with collaboration with the ICB.
As an emergent leader in the ICS and new to the system I am increasingly concerned that innovation and collaboration is stifled by conflicts of interests which are not declared nor managed
Flexible meetings, focus on non medics and support for clinical care
ICB not using NHSE-speak with clinicians for a start, ICB team srealising the people who put themselves forwards to lead are usually unrepresentative of practising clinicians - talk to a wider range
regular meet ups on teams to build relationships and keep up to date
Ensure more open lines of communication are established
Shared professional leads and AHP networks, especially with frontline clinicians.
making sure that geography and demographics are recognised in all areas - blanket decisions may not always be appropriate
Ask all to make a commitment ! work with others for best outcomes to stop the re admission wheel
see above - and better engagement from acutes - which has been difficult given the operational pressures they have
Continue systems approach and ICB roles supporting the collaboration and work streams hands on.
By making it easier for peers at all levels to become aware of each other and reduce silo working
More direction, sometimes different groups meet and have overlapping objectives. Could be streamlined with more clear purpose and action.
Collaboration and innovation cannot be bad, depends what you want to achieve, its usually a lot of meetings with zero net output
We often get unnecessary rude letters from general practitioners, mostly directed to junior doctors. That is very distressing and unfair. If there something that's need changing GP's should give feedback to ICB rather than writing rude letters to junior doctors and nurses. There should be a designated ICB liaison person for each speciality.
Yes , invest to save , allow some funding for local projects , if successful evaluate them properly and then consider rolling them out across the system .
much more communication and achievement of projects and improvements locally for patient care
Better understanding of the local demographics especially when services are 'out of area' or in different counties. 'One size' doesn't fit all.
specific departments including clinicians and managers meeting up across the ICB rather than all management staff
With such plate forms like what we are working now, with extremely competent and helpful guidance of our ICB fellowship team, I would like to quote an example, when I was quite keen to join a meeting in Cambridge about setting " Women health hub", it was arranged by Miss Rhi, with a lot of efforts, since was not under our ICB, so by this mutual trust and cooperation I see the collaboration and innovation going a long way together with ICB and system partners.
Variable
More contact with frontline staff
encourage clinicians to attend - make attendance accessible for neurodiverse people
need to collaborate at a lower level, doesnt matter that manager work together its front line staff that need to know who to speak too.
ICB need to listen to staff who were not part of the NCHC. Just listening to these NCNC staff means old difficulties keep being replicated
Encouraging learning across organisational boundaries
if we focused on outcomes as opposed to finance
Greater links with NICHE and the funding grants available within this platform can transform ideas into practice.
ICB seems like something external. It would help if all new posts in the ICB are join with a NHS trust so that staff have contacts on both sides.
I am not sure which system partners the ICB has or what current collaboration or innovation is currently happening.
Time away from the "day job" - away day events to network and build relationships
Have a more specific pathway for each clinical professional group which includes clinical and professional support and structures. Find it frustrating that am being 'lumped' into a generic AHP grouping within my service when the clinical responsibilities and developments are different per clinical profession. Education of senior management of risks associated around each discipline and different levels of expertise required. One size does not fit all!

12. Outline some examples where shared learning and/or collaboration has resulted in improved outcomes for patients in your experience.

Transformation and Collaboration Initiatives:

- MSK transformation, pelvic health collaboration, patient safety specialist collaboration, and the development of a virtual ward.
- PMH AHP collaboration focusing on putting patients first and agreeing on a joint pathway.
- Increasing cohesion within teams and a focus on working together more effectively.

Learning and Development:

- Focus on health equity through skills learned at TDF (The Development Fund).
- Sharing of learning, collaboration with King's Fund on NHS funding, and levelling up by SEL ICB.
- Collaborative efforts for population health management strategy writing.

Impactful Collaboration:

- Successful collaborations such as shared care records launch, bladder and bowel group, frequent attenders analysis, and complex cases meetings.
- Improved access to services through unified pathways and collaborations in pelvic floor services and community mental health.

Prevention and Unified Pathways:

- Localities collaborating to enhance prevention and urgent and emergency care (UEC).
- Successful collaboration in reducing waiting lists through urogynaecology collaboration across trusts.

Patient-Centric Initiatives:

- Initiatives focused on patient safety, such as the development of a virtual ward and joint formulary work.
- Collaborations in the Worries program to support primary school teachers in delivering evidence-based approaches for child anxiety.

System-Wide Learning and Training:

- Learning from population health management strategy development and collaborations within specialist outpatient meetings.
- Collaborative in-service training to community physios and joint formulary work.

Enhanced Communication and Engagement:

- Improving front door time to initial assessment in the emergency department through collaboration.
- Funded PCN leads improving communications between primary care providers and encouraging expressions of interest in services.

MSK transformation, pelvic health collaboration, patient safety specialist collaboration, virtual ward(though further to go with this)

PMH AHP collaboration- putting patients first and agreeing a joint pathway

Starting to work as a more cohesive team

Focus on health equity through skills learned at TDF | Sharing of learning by SEL ICB levelling up | Learning with King's Fund on NHS Funding

Collaboration at localities have helped prevention and UEC but funding runs out, and then engagement runs out

pelvic floor services - now single point of referral, single pathway whatever provider happens to provide that bit, similarly community mental health - easier to access, unified pathways, better service for patients,

Not yet, but delighted to read about Shared Care Records launch

Bladder and Bowel group. Frequent attenders analysis .

In the Complex cases meeting between clinicians at the Colman Centre for Specialist Rehabilitation and the Norfolk and Suffolk Foundation Trust. Allowed discussion of a complex patient where it was difficult to identify an appropriate path forward. Shared learning helped develop an appropriate treatment plan.

Audit in diabetes general practice

Working on Worries programme. Collaboration between ICB, NSFT, Education, VCSE and CCS to support primary school teachers in delivering an evidence based approach for child anxiety. sch

In the South place specialist out patient meetings , AHP's from their disciplines get to discuss what they have been working on and we share learning and experiences that we would not have known our colleagues had already dealt with.

Writing our population health management strategy has been truely collaborative and inclusive and should result in a programme of work that delivers for patients and communities.

Consultant outreach for diabetes - great service with support for general practice from secondary care

S1 & record-sharing

collaboration to improve front door time to initial assessment in the emergency department

a service user with a long history of drug missuse working with all others involvered MDT style everyone was aware of what others were doing there was better awareness and continuity NO CONFUSION resulting in a stable situation removing repeated crisis and admission to hospital

The supporting ICB roles in Older Person Medicine and Frailty are softening traditional boundaries. In HCS a strategy approach to system workforce planning and development is in progress.

Joint formulary work

Clinical sharing always helps, we hold MDTs within the ICB which help us plan treatment, we also share pathways and policies

Nothing to share

Locally led care home teams were able to support and train care home staff and reduce pressure on the hospital by avoiding admissions and also support primary care

funded PCN leads have improved communications between primary care providers and encouraged Expressions of interest in services

collaboration with urogynaecology across trusts to help reduce the waiting lists when a specific staff member was on long term sick leave

Recent PTP pathway - ICB and YMCA MH initiative

catheter care network - HOUDINI audit and re-launch of the national catheter passport

Have worked with RAFT at QEH to be aware of an incoming A&E patient and their needs ready for discharge`

Providing in service training to community physios

lessons learnt after the death of people in settings, but this happens too late.

NICHE collaboration events, nursing away days, team away days, regional roundtables

Pathways between SLT community and acute services, developing seamless service provision and follow up.

13. How can we ensure that CCP leadership is built into the system and seen as a key enabler to strategic objectives?

Integration of AHPs:
- Lack of a defined substantive Chief AHP role in the ICB, emphasizing the need for better integration of AHPs.

Regular Meetings and Commitment:
- Regular meetings, particularly as Clinical Programme Planning (CPP), as a key element of effective collaboration.
- Emphasizing the importance of protecting time, providing varied opportunities, and fair remuneration for meaningful engagement.

Diverse Representation:
- Inclusion of diverse CCPs on every board, committee, and forum, ensuring varied voices in decision-making processes.
- Calls for publishing how engagement has occurred and promoting inclusivity for nurses and frontline team members.

Efficient and Relevant Meetings:
- Acknowledging the challenge of balancing efficient meetings with clinicians' busy schedules.
- Highlighting the importance of CCP leadership in providing on-the-ground knowledge to make meetings relevant and effective.

Clinically Led Organizations:
- Advocating for organizations that are clinically led and manager-supported to ensure a balance between leadership roles.
- Proposing that professional system workshops involve all clinical staff.

Visibility and Representation:
- Ensuring visibility and representation of CCP locality leads, offering mentorship, regular meetups, and opportunities for development.
- Emphasizing the need for visibility and training as part of basic training for CCP leaders.

Strategic Objectives and Leadership:
- Suggesting that strategic objectives need to be developed collaboratively and promoting good clinical staff on the wards.
- Recommending innovative leadership posts that build on core skills rather than focusing on specific professions.

Clinical Frontline Leadership:
- Encouraging leadership from the clinical frontline rather than from office/internet management.
- Embedding feedback mechanisms and discussion opportunities into planning and pathway design.

Inclusive Planning and Pathway Design:
- Acknowledging the importance of clinician attendance by protecting time in demand and capacity models for workforce planning.
- Emphasizing the need for strategic objectives to be developed together, promoting good clinical staff on the wards, and creating innovative leadership posts.

Effective ICT Network:
- Building a better-integrated ICT network for effective communication and idea-sharing across the ICS.

Engaging Younger Clinicians:
- Reaching out earlier to younger clinicians and providing training and opportunities for them to make a difference.

Ensuring Views are Listened to:
- Emphasizing the importance of seeking out and listening to the views of all clinical staff.

AHP Leadership and Inclusion:
- Inclusion of the CCP leadership group and having a specific AHP lead within organizations beyond workforce considerations.

Build into all trust strategies
AHP's still not really integrated as no defined substantive chief AHP role in the ICB
regular meeting as CPP
Protect time, provide varied opportunities, and renumeration. Don't simply play lip service to it
Commitment at the highest levels of the system, again demonstrated by behaviour
diverse CCPs on every board, committee, forum etc who use their voice in the meetings and take the outcomes out of hte meeting to share with professional colleagues
Publish how engagement has occurred.
Make time for it promote it and open up to nurses / Team members on the front line.
This is difficult. Clinicians have ever growing waiting lists and so are disinclined to spend time in meetings which are not proven to be valuable. However systems are more efficient where there is not replication and where learning is shared. The ICS can learn so much from CCP leadership. There is so much "on the ground" knowledge available. For it to be effective, both parties need to feel that is time well spent. CCP leadership need to know that they can influence objectives so they are relevant to their patients and team. If the time is not usefully spent, CCP leadership will disengage and not prioritise ICS activities. You might get one opportunity to engage people, if there is a feeling of the time being wasted, it is unlikely you will get attendance at future meetings. If a meeting has unrealistic goals or is very upbeat or positive, people may not speak freely as they don't want a reputation of being negative. If things are too negative, participants may leave feeling overwhelmed and disillusioned and again might not find their precious time usefully spent. It's a difficult balance to obtain.
Good organisations are clinically lead and manager supported. We need to get this right.
Ask all professional system workshop
CCP members integrated across boards across providers and ICB. CCP members reporting to ICB boards directly
ensure representation from all bands of clinical staff
Ensure that CCP leaders are invited to the right meetings, are given the say at the right time on key decisions and t
More opportunities for those across the bands
no idea - that would conflict with NHSE mandates for you
time in job plans, regular meet ups and mentorship from different levels to support progress and development between all levels and areas and develop relationships
I think the CCP locality leads need to be more visible
More visibility.
part of basic training
It has to be moving forward we have to relise that we need to do this the prize is a better outcome for the service user but we all gain from less confusion better use of time and value for money
AS above - ensure policies are clinically led based on current best practice and innovation.
CCP Leadership integral/integrated into Clinical Programme Board's.
A seat for the right people at "the table" would be a good start - no finance of commissioning decisions to be made without appropriate clinical input
Would be better to keep it localised, what is best for one hospital or area may not be relevant in another. With large collaborations the largest organisation in the collaboration can take over. Large collaborations take a long time to take action and decisions.
by listening to the clinicians and not sidelining them!
By listening directly to clinical workforce, ground crew knows how it works the best.
Reach out earlier to younger Clinicians and Cares and offer training but also a develop a system where they can see that they make a difference and are not a token presence
Need to lead from clinical frontline rather than from office/internet management
embed feedback machanisms and discussion opportinuties into planning and pathway design
tell all clinical staff that it goes on and ask them to put ideas forward even if they are not in management roles
The outcomes for both patients and the HCP.
More time to learn
acknowledge the importance of clinician attendance by protecting the time in the demand and capacity models for workforce planning
need to be actual clinical staff leader not managers with poor clinical experience or knowledge.
This question doesn't make sense. The system needs to develop stargetic objectives together - not just aim to achive what non-clinical managers have deemed necessary. Promote good clinical staff on the wards - don't just give them 'management' jobs away from direct patient care.
Create innovative leadership posts, which build on core skills rather than for a specific profession.
Having a better integrated ICT network which all members of the ICS can connect to and share ideas/ generate discussion
Time and money with it to follow.
Making sure that views are sought out and listened to.
Inclusion of the CCP leadership group and having a specific AHP lead within organisations (not just around workforce and not using clinical education to fill the void)

14.How can we embed a culture of shared learning, supporting collaboration and innovation with partners, patients, service users, residents and communities?

Patient-Focused Collaboration:
- Emphasizing a focus on patient needs rather than organizational interests.
- Encouraging an organizationally agnostic approach to decision-making.

Effective Collaboration and Leadership:
- Promoting understanding of effective collaboration, inclusive leadership, trust-building, and fostering positive attitudes toward risk.
- Advocating for regular meetings and the active creation of spaces for collaboration.

Capacity Building and Head Space:
- Providing capacity and headspace for collaborative activities, avoiding time constraints during lunch or between other commitments.

Openness and Evidence-Based Decision Making:
- Encouraging openness, sharing, and using evidence to prioritize activities.
- Promoting regional meetings and smaller units working locally, exchanging ideas and sharing best practices.

Engaging the Busiest Staff:
- Acknowledging the challenge of engaging the busiest staff and emphasizing the importance of having a clear plan with influential strategies.

Integration into Job Plans:
- Advocating for building time into job plans to contribute effectively to collaborative activities.
- Highlighting the need for manager training to support this integration.

Community Engagement and Education:
- Working with VCSE for more effective engagement with communities.
- Utilizing patient groups and providing clear routes for feedback to improve service delivery.

Evaluation and Lessons Learned:
- Identifying challenges with embedding evaluation into programs of work.
- Advocating for honest feedback, 360-degree feedback, and a bottom-up approach.

Visibility and Accessibility:
- Emphasizing the need for more visibility and self-referral access for patients and professionals.
- Suggesting the implementation of formal managed clinical networks.

Inclusive Decision Making:
- Involving all system partners, community champions, and leaders in decision-making processes.
- Encouraging transparent purpose and vision-sharing.

Cultural Shift and Mindset:
- Acknowledging the existing culture of shared learning from mistakes.
- Advocating for more opportunities for fellowships and support for all healthcare professionals.

Communication and Updates:
- Providing accessible communication and updates for all roles.
- Encouraging an open culture that values all individuals, irrespective of diverse backgrounds.

Research and Evaluation Skills:
- Equipping clinicians with research and evaluation skills.
- Encouraging programs that develop skills and projects, such as ARC implementation fellowships.

Strengthening Partnership Boards:
- Strengthening existing partnership boards, making them centrally located for easy community access.
- Facilitating strong partnership boards for specific groups, like those run by Autistic people for creating change.

Listening and Learning:
- Emphasizing the importance of listening and learning from service users on the ground.

Accessible Information and Technology:
- Advocating for accessible information and consistent use of technology across all services.
- Suggesting the creation of shared digital services to enhance collaboration.

focus on patient need rather than organisational. Organisationally agnostic approach
everyone understanding how to effectively collaborate. inclusive leadership, building trust, culture and values, developing positive attitudes to risk
regularly meet
Actively create and facilitate the space for this to occur
Giving the people within it capacity and headspace for this activity: not squeezed into lunchtimes or in between other commitments
openness, sharing and using evidence to prioritise what we do and don't do
Regional meetings
Smaller units working locally. That then come together regularly and exchange ideas , examples of good practice. Sharing lessons learnt from Datix has been a start.
Again this is challenging. You will receive feedback from people who have the time to give feedback, which means that you might miss the busiest staff. Having a clear plan and clear ways to influence the plan can be helpful.
Need to build time into job plans to effectively contribute do these activities. Need manager training to eable this .
Integrated events
Work with VCSE to more effectively engage communities etc on a regular basis. Sharing positive stories and asking them to jointly solve challenges
use patient groups more , i.e GP patient group as drivers for our services ,ensure their is a clear simple easy route in to feedback to the trust , we did a you said we did for staff survey. We also need to advertise our positive feedback and welcome what might be negative feedback so we actually know we are delivering the service the patient expects and if not be able to educate as to why this is with research . Better education to Primary care as they set inappropriate expectations for their patients , this may be due to them not having enough contact with us to know what it is we actually do !
Evaluation is till not embedded into programmes of work so lessons learned are not being shared or taken forward so history repeats itself. There are some issues around reluctance to embrace culture change.
Honest feedback, 360 degree feedback
bottom up - start with the residents
the regular learning events that already happen but maybe more frequently and recorded if can't attend
better comminication
More visibility
self referral access for patients and professionals working in different comminity settings plus online access to resources
we have to look at what some are trying to do this positive way of working MDT is often shatted by those who what to stess what they see as there responsibility and also what they see as their budget often trying to unload the finical burden to otherss
Consider having formal managed clinical networks (Scotland has been very successful for years)
Involve all system partners and community champions/leader in developments, transparency, share purpose and vision.
Keep talking and raising its profile
I agree that shared learning is important, but for action and decisions should be local to the area and local communities need to be involved.
We already have a good culture and mind set of shared learning from mistakes, these events are most productive when clinically ledect clinicians times
Involve all stakeholders in decision making process even when the decision is unpalatable
Collaborative working at all levels , starting with integrated neighbourhood teams , through place boards and partnerships and into the ICB
Ask patients, service users etc. directly in personal way rather than feedback surveys so more inclusive of all groups
more networking opportunities, accessible forums, case studies, welcoming feedback from primary care providers
Get learning across the breaks e.g. GP and acute hospitals nursing homes and acute hospitals
By providing more opportunities for fellowships and support to all HCP and the admin teams.
Open culture
more effective use of MDT environments
give people time to recieve education, time to develop the change without pressure to change several things at the same time. Accessible communication and updates for all people in all roles.
Listen, value all people not just those form diverse ethnic, social or other diverse backgrounds.
Equip clinicians to develop research and evaluation skills. Programmes like ARC implementation fellowship develop skills and projects.
Use existing forums do not re-create really strong parternship board forming for people with Autism , run by Autistic people who want to create change but need to be enabled by the system to participate and contribute. -
Strengthen our parthership boards and allow them to be more centrally located to allow patients and cares and communities to access them freely and easily
BY working on the ground with service users.
Listen, learn?
Having opportuntities to collaborate both within and across professions. Ensuring that all registered professionals are able to contribute to plans and that no groups are excluded.
Accessible information and supporting Communication Access UK - using technology consistently across all services. Shared Digital service would also help.

15 and 16. How good is the ICB at supporting staff to become CCP leaders of the future? How can we encourage more CCP Leaders to be involved and invested in ICS planning and delivery, in addition to time, support and infrastructure?

Representation Matters:
- Advocating for wider representation beyond NCHC in leading projects, recognizing the importance of diversity.
- Highlighting the need for a defined chief AHP role in the ICB.

Funding and Time Protection:
- Emphasizing the need for funding more posts and protecting time with varied opportunities and remuneration.
- Demonstrating that input from CCP leaders makes a difference in decision-making.

Communication and Information:
- Calling for better and broader communications within the ICS.
- Acknowledging the importance of making documents readable and digestible.

ICB Engagement and Understanding:
- Expressing the need for clearer information for frontline workers to understand the role and progress of the ICB.
- Encouraging the ICB to give back to clinicians through continuous professional development (CPD).

Time and Funding for Involvement:
- Stressing the importance of ensuring funded time for involvement and backfilling, particularly in primary care.
- Suggesting protected, fully funded, backfilled time for recognizing leadership capabilities.

Visibility and Recognition:
- Advocating for more visibility of CCP leaders, including meetings with clinicians.
- Recognizing the need for roles to be valued and funded appropriately.

Engagement Strategies:
- Recommending strategies like picking up the phone and directly engaging with clinicians.
- Suggesting the role of a specialty liaison officer.

Career Development and Recognition:
- Proposing roles offered over a suitable time period (e.g., 2-3 years) for career development.
- Recognizing the importance of accreditation and recognition for training courses.

Consultation and Engagement Platforms:
- Emphasizing the importance of consulting frontline clinical staff to understand their needs for service improvement.
- Recommending protected learning time, backfill, and more accessible forums for engagement.

Measurable Progress and Outcomes:
- Stipulating the importance of ensuring that meetings lead to actual progress and outcomes.
- Encouraging openness about what is happening within the ICB.

Motivation and Outcomes:
- Recognizing that motivation among CCP leaders and outcomes from their seniors can drive positive engagement.
- Suggesting accreditation and recognition for training courses.

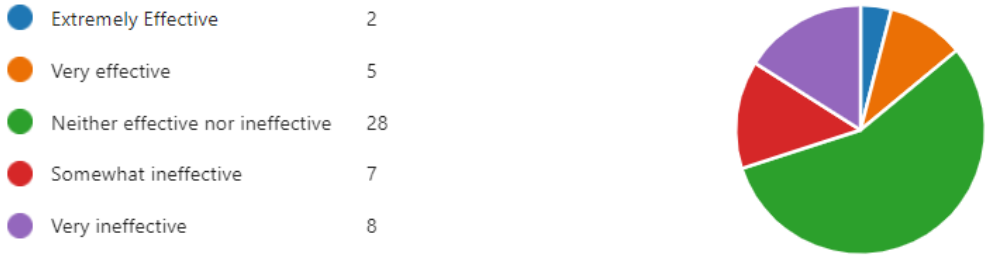
Clarity in Engagement Targets:
- Advocating for active descriptions of who needs to be involved in engagement initiatives.
- Addressing the issue of too many acronyms and lack of awareness about CCP.

Relevance and Openness:
- Stating the importance of making ICS or CCP leadership more relevant to everyday work.
- Advocating for openness about the workings of the ICB to enhance patient awareness.

Investment in Training and Development:
- Calling for investment in training at all levels, providing examples of successful programs like the JPUH NMAHP Research and Evaluation scholarship.

ICS-Wide Leadership Development:
- Recommending ICS-wide programs to develop and expand leadership skills of senior clinicians.
- Encouraging collaboration with local trusts and ring-fencing funds for leadership training and roles.

Tailored Opportunities for CCP Leaders:
- Proposing the creation of opportunities specifically tailored for CCP Leadership but not on fixed-term contracts.



making colleagues aware. It will take time. Role modelling
First of all cast your net wider than NCHC in terms of leading on projects, representation matters especially no Defined chief AHP role in the ICB
fund more posts
Protect time, provide varied opportunities, and renumeration. Don't simply play lip service to it
Demonstrating that their input makes a difference in decision making
better and broader comms
Think this program is quite good and provides opportunities
Back to the floor exercises so staff know who decision makers are.
Depending on our line management structures, many of us had not had any contact with the previous CCG structures. Commissioning was considered commercially sensitive and very little communication happened between CCP leaders and the CCGs. There is little knowledge about what CCP leaders can influence with the new ICS. In responses to forms, it would also be helpful to not have to fill in every question. Requiring an answer to each question means I would probably not choose to complete the form at all as it will be too time consuming. I am only able to complete this form today because I had a patient cancellation- otherwise it would have been too time consuming. I think getting some information from an incomplete form would be better than a very poor response rate due to it taking so long because of all the required answers.
Need to ensure funded time. It will not work on peoples good will given managers want to micromanage staff time and act like controlling parents.
Time and funding, released from clinical practice. In primary care this is restricted for nurses
ICB also giving back to clinicians through CPD?
show how the engagement translates into more effective patient care.
The additional support in terms of leadership reflective sessions is very welcome, perhaps these could be recorded so that those of us with heavy clinical committments can attend. The same with the catch ups with Andy Griffiths. Some practical sessions on writing business cases, economic evaluation methodology would be welcome.
More clear info for those working on frontline to really understand what the icb does
pay their organisations to release them AND find backfill
time in job plans
Protected, fully funded, back-filled time to enable people to recognise their leadership capabilities.
More visibility, meeting clinicians etc.
give allocated time
nurture the MDT seed to grow
Demonstrate an ability to deliver change
Great plans shared but unsure on the progress of these.
Speak their language - be willing to listen and bring them up to speed in a supportive way
Recognising that people need the 'time' to be involved, need adequate numbers of staff, then people are not so busy that they have no time to get involved.
Pick up the phone and chat to them
Speciality liaison officer
work needs to be valued and funded appropriately . Roles should be offered over a suitable time period eg 2-3 years to help career choices
Consult with frontline clinical staff to understand what works and what takes their time away from service improvement and delivery.
protected learning time, backfill for time, more accessible forum and options to engage
By ensuring that any meetings come up with actual progress not just more papers suggesting that something has been done or that something should be done (as it probably will not be done as there are too many other things to catch up with rather than make progress)
It depends on the resources available and motivation among provisional CCP LEADERS, however, by looking at the outcomes of there seniors and the way they can provide positive outcomes could motivate them.
Some accreditation and recognition for these courses.
actively describe who needs to be involved - if you want clinical lead nurses to be involved, write to them directly - if you want OT leads, write to them directly. Who is it you want?
Never heard of CCP before this, too many acronyms also
Be more open about what is going on. We only hear about what the ICB states must happen- there appears to be very little awareness of what it is to be a patient
Invest in training at all levels. JPUH NMAHP Research and Evaluation scholarship is an example of this
make it relevant to all parts of the system.
ICS wide programmes to develop and expand the leadership skills of senior clinicians - more variety of face to face events
Speak to local trust and ring fence funds to empower managers (line managements) to support clinicians to take on leadership training and roles
I may be a lone voice but ICS or CCP leadership is not part of my everyday work thinking which is why I've found it hard to complete this survey
Making documents readable and digestible. Providing opportunities to hear about things in a bite sized way.
Create opportunities specific for CCP Leaders and not on fixed term contracts.

2022/23 CCPL Feedback Survey - Themes and Priorities

1. Communication and Engagement:
- Theme: Colleagues emphasise the need for effective communication and engagement strategies.
- Priority: Prioritise improving communication channels, making information accessible, and engaging clinicians actively.

2. **Funding and Time Protection:**
- Theme: Consistent mention of the importance of funding, protecting time, and providing adequate resources.
- Priority: Prioritise securing funding, protecting time for engagement, and ensuring resources are available to support initiatives.

3. Leadership Development:
- Theme: Recognition of the need for leadership development and training at all levels.
- Priority: Establish programs for leadership development, training, and skill-building, ensuring accessibility for all levels of clinicians.

4. Role Modelling and Representation:
- Theme: The significance of role modelling and the need for wider representation.
- Priority: Prioritise initiatives that promote role modelling, diversify representation, and address gaps in leadership roles.

5. Demonstrating Impact and Progress:
- Theme: A call for demonstrating tangible impact and progress resulting from clinician engagement.
- Priority: Establish mechanisms to showcase how clinician input translates into improved patient care and visible progress.

6. Learning and Development Opportunities:
- Theme: A consistent desire for learning and development opportunities, both formal and practical.
- Priority: Provide varied opportunities for learning, including reflective sessions, practical training, and continuous professional development.

7. Visibility and Recognition Efforts:
- Theme: Emphasis on increasing visibility, recognizing contributions, and creating a culture of appreciation.
- Priority: Prioritize initiatives that enhance visibility, recognize individual contributions, and foster a culture of appreciation.

8. Accessibility and Inclusivity:
- Theme: The need for inclusive engagement methods, accessible forums, and accommodating diverse needs.
- Priority: Ensure that engagement efforts are inclusive, forums are accessible, and initiatives accommodate diverse roles and responsibilities.

9. Clarity and Relevance of Information:
- Theme: Requests for clear and digestible information, along with relevant and targeted engagement.
- Priority: Improve the clarity of information, make it digestible, and tailor engagement efforts to be more relevant and targeted

10. Local and System Collaboration:
- Theme: The importance of collaboration at local and system levels.
- Priority: Foster collaboration by strengthening relationships at the local level and ensuring alignment with broader system goals.

11. Feedback Mechanisms and Flexibility:
- Theme: Suggestions for effective feedback mechanisms, flexibility in engagement, and responsiveness to diverse needs.
- Priority: Establish clear feedback mechanisms, ensure flexibility in engagement structures, and be responsive to the dynamic needs of clinicians.

12. Empowering Clinicians:
- Theme: Calls to empower clinicians through involvement in decision-making, representation on boards, and support for leadership roles.
- Priority: Empower clinicians by involving them in decision-making processes, facilitating representation, and creating pathways for leadership roles.