Our Healthier South East London
Integrated Care System

NHS

Developing Clinical and Care Professional System Leadership capacity and capability

Part 1 of 2: Infrastructure and capacity

August 2021

Table of Contents

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Integrated Care System

1. Background & Purpose

What is the purpose of this pack?

This pack is:

- ✓ An outline of how we plan to create the capacity, capability, and coordinating infrastructure necessary to enable Clinical and Care Professional Leadership (C&CPL) at ***a system level*** to support effective integration as an ICS
- ✓ A description of the proposed purpose, functions and forms for C&CPL in the new ICS with a view to recruiting and developing a diverse, energetic community of leaders from across our partnership.

This pack is not:

- ✗ An attempt to define the ICS Governance but rather how clinicians and care professional system leadership is effectively reflected within the agreed ICS governance
- ✗ Intended to describe the extent of clinical and care professional leadership that currently exists or should exist within our partner organisations as an ICS or within specific transformation programmes
- ✗ An attempt to define, dictate or in any way limit current or future investment in the development of C&CPL by Providers, Places or Collaboratives.

What is our vision: A vibrant community of clinical and care professional leaders

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Our vision for clinical and care professional system leadership is for a vibrant community of leaders working across boundaries all over south east London, with clinical and care professional (C&CP) expertise at the centre of how decisions are made and enacted across the system in the interests of our patients and population.

We want to support an environment where clinical and care professional system leaders have the ***capabilities, opportunity and motivation*** to make system leadership a truly impactful, rewarding and joyful experience for them and our system. Achieving this 'quadruple aim' will enable us to achieve our purpose as an ICS - to improve healthcare experiences and outcomes for our population. A new governance infrastructure is required to support and coordinate this leadership community.

However, as we point out in this pack, whilst new governance arrangements are necessary, they are not sufficient, particularly when it comes to building capability. A separate but interlinked workstream - to develop a **South East London Systems Leadership Academy** - is running in parallel to this and should be read/considered alongside what follows in this pack.

This pack sets out proposals for how we develop a governance model for clinical and care professional system leadership that:

1. Delivers on our ICS System Development Plan commitments on supporting clinical and care professional system leadership
2. Supports the ICS in meeting our 4 overarching commitments to:
   - ➢ Improve outcomes in population health and healthcare
   - ➢ Tackle inequalities in outcomes, experience and access to care
   - ➢ Enhance productivity and value for money
   - ➢ Help the NHS support broader social and economic development
1. Reflects the NHSEI Design Framework - in particular ensuring C&CP leadership is at the heart of new overarching governance arrangements for our system by Autumn 2021
2. Honours the engagement and feedback of over 120 clinical and care professional leaders across south east London who have helped to co-design these proposals.

Overview of our process - intense engagement over four months to co-design the approach and outputs

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Workstreams

Engagement
- Engaged 100+ leaders across SE London

Inspiration
- Learnt from systems in UK, Europe and US

Governance
- Reviewed current model in comparison to others

Core themes

Purpose, focus and ambition
- Start with the why
- Focused on areas of most system potential
- Chance to be world leaders

Culture of connection and learning
- Permissive structures enabling connection
- Underpinned by psychological safety
- Convening for maximum impact

Inclusion, support, and interdependence
- Need for diversity of leaders
- Leadership development and support
- Interdependence with executive leadership

Implications

Principles
- Set of six principles to guide future development

Recommendations
- Updated governance model to support vision
- Community development, using label of a 'system leadership academy'

Connected issues
- Integration with executive and managerial leadership
- Patient & public involvement
- Data, digital and information

We agreed and used six principles to underpin system leadership development

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Integrated and interdependent	Designed to ensure C&CP system leadership is fully integrated with executive and managerial leadership in ICS operating model, system governance, structures and networks as a core required function of the SEL ICS.
Supportive of ICS strategy	Designed to support delivery of a clear, purposeful and motivational ICS strategy that describes why the ICS exists and how it will improve patient lives.
Focused on impact	Focused on key functions and programmes of work that have a clear benefit of being addressed at system level and what leaders can collectively contribute to the broader system.
Inclusive in every way	Inclusive and reflective of the diversity, breadth and depth of our system across care settings, place, organisations, professional groups and networks and the population we serve.
Supportive of system leadership development	Designed to support the development of skills, behaviours, tools and relationships required to maintain a community of innovative and impactful system leaders working effectively across spatial, organisational and professional boundaries.
Focused on learning	Designed to support develop and foster a culture of learning underpinned by psychological safety. Governance must support us to share our successes and learn from them across the system.

Our four objectives for this work - To agree our purpose, functions, forms and funding for clinical and care professional system leadership

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We have learnt from our research that there are four key reasons to **establish strong 'scaffolding'** to support a sustained, efficient and more distributed approach to systems leadership. In line with the SEL ICS development 'Ways of Working' and 'Systems Architecture' workstreams, we propose building on the models of Canterbury NZ, south-west London and Greater Manchester, and co-designing a version of these that work for SEL.

Alongside this, there is a clear and urgent need to support care professionals entering systems leadership roles. In conjunction with the proposal for updating the ICS governance model in this pack, we are setting out how we can develop a central function responsible for building and supporting the development of the community of clinical and care professional leaders across south east London.

Updating ICS governance model to support vision by...

1. Agreeing the purpose and functions of clinical and care professional systems leadership for the ICS
2. Establishing enabling structures and ways of working
3. Confirming roles needed to support effective delivery of functions and operation of structures
4. Securing funding for roles, protected time and systems leadership development and support

The South East London Systems Leadership Academy

- Systems leadership development curriculum
- Network for SEL next generation systems leaders
- 'Walking in each others shoes' shadowing programme
- Community of practice and inspiration for SEL systems leaders
- SEL Challenge fund: Support for systems improvement projects
- SEL clinical and care professional leaders conference

2. Overview of proposals

Building capability: Governance is necessary but not sufficient

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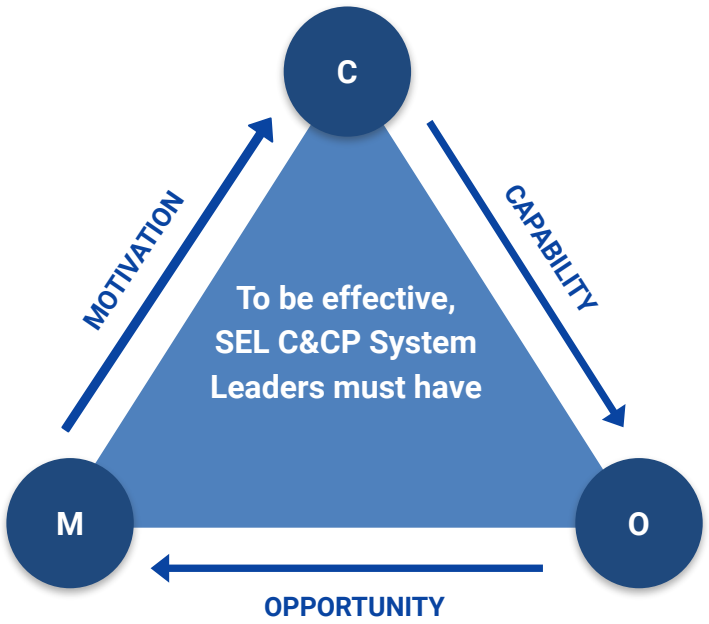
The conversations we have had with domestic and international leaders such as Canterbury in New Zealand and the Accountable Care Learning Collaborative in the USA confirmed that, for any high performing healthcare system, three fundamental conditions must exist if clinical and care professional system leaders are to succeed - irrespective of any Governance we put in place. These are also reflected in the NHSEI guidance for ICSs on supporting clinical and care professional system leadership (see Annex B).



1. **Capability**. Those clinical and care professionals whom we ask to lead across the system must be supported to develop the capabilities they need to succeed. *Our proposed south-east London Systems Leadership Academy can respond to this need.*
2. **Opportunity.** Even with the right skills, knowledge, behaviours and structures, if our system leaders do not have the protected time to do what we are asking them to do they cannot be expected to succeed. *The most important investment we must make is in protected time and funded roles.*
3. **Motivation.** We need to encourage, recognise and reward the system leadership behaviours we need from our clinicians and care professionals. Creating a permissive environment that is empowering, and ensures that they have the autonomy and agency to act. *We can do this by protecting time, funding roles, modelling desired ways of working, investing in exemplar projects and programmes and providing opportunities for personal and professional growth via our Systems Leadership Academy.*

Proposal for C&CP system leadership at a glance: Purpose, Function and Form

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1. Purpose: Governance design principles

1. Designed to ensure C&CP system leadership is fully integrated with executive and managerial leadership in ICS operating model, system governance, structures and networks as a core required function of the SEL ICS
2. Designed to support delivery of a clear, purposeful and motivational ICS strategy to improve health outcomes for the population of south east London
3. Focused on key functions and programmes of work that have a clear benefit of being addressed at system level and what leaders can collectively contribute to the broader system
4. Inclusive and reflective of the diversity, breadth and depth of our system across care settings, place, organisations, professional groups and networks and the population we serve
5. Designed to support the development of skills, behaviours, tools and relationships required to maintain a community of innovative and impactful system leaders working effectively across spatial, organisational and professional boundaries.
6. Designed to support, develop and sustain a culture of learning underpinned by psychological safety

2. Functions: Areas of focus for system leadership

1. Population health outcomes/inequalities
2. Care pathway transformation/innovation
3. System-wide clinical strategy
4. Clinical and Care workforce resilience
5. Quality Assurance and Safety
6. Patient and public engagement
7. Continuous improvement
8. Professional leadership support and professional development
9. Leadership in research & evidence creation, discovery and spread
10. Care standards

3. Form: Structures and ways of working

- New Clinical & Care Professional System Leadership Group
- C&CP system leadership to be reflected in membership and operation of formal ICS Governance structures:
  - The Integrated Care Partnership
  - The Integrated Care Board
  - The ICS Executive
  - The Integrated Governance and Performance Committee
  - The Population Health Management and Inequalities Executive
  - The System Quality Board
  - The People Board
  - The Patient and Public Engagement Group
  - The Estates Board
  - The Digital Board
  - All core programme boards for care pathway transformation
- Link to London region via LCAG and clinical networks
- Investment in Clinical Networks and leadership
- Identified the right spatial level to locate and support system leadership and enabling governance
- Mix of appointed & accountable individuals e.g. CMO, CNO and shared/distributed leadership
- Setting up a south-east London Systems leadership Academy so all leaders have the capabilities and support to succeed.

We will also use the ICS Design framework C&CPL ambitions to strength test our proposals

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In June 2021, NHSEI published the first version of the ICS Design Framework, which sets out future ambitions for ICSs including describing the features of an effective model for clinical and professional leadership. We contributed to the the guidance on clinical and professional leadership in some detail and our proposed model has been informed by this document and responds to it in full, so that any investment can be made with confidence in regard to national support and any future assurance processes.

All ICSs should develop a model of distributed clinical and care professional leadership where there should be…			
1	Effective structures and communication mechanisms to connect clinical and care professional leaders at each level of the system. (C&CP leaders) are fully involved as key decision-makers, with a central role in setting and implementing ICS strategy. They should reflect the learning and experience gained from CCG clinical leadership, building out from this to reflect the rich diversity of clinical and care professions across the wider ICS partnership, including health, social care and the VCSE sectors, embedding an inclusive model of leadership at every level of the system.	**6**	These arrangements should support and enhance those of the organisations within the ICS footprint, which are responsible for the professional and clinical leadership of their people and services.
2	A culture which 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	**7**	We encourage systems to consider how they could use a peer review approach to support their development in this area, buddying with other systems to undertake their assessment and develop subsequent plans.
3	Protected time, resource support and infrastructure for clinical and care professional leaders to carry out their system leadership roles	**8**	For the NHS ICS body, the clinical roles on the Board, described in the 'Governance and management arrangements' section, are a minimum expectation, ensuring executive-level professional leadership of the organisation. Individuals in these roles are expected to ensure leaders from across clinical and care professions are involved and invested in the purpose and work of the ICS.
4	Clearly defined and visible support for clinical and care profession leaders, including support to develop the leadership skills required to work effectively across organisational and professional boundaries	**9**	The ICS NHS board will be expected to sign off a model and improvement plan for clinical and care professional leadership that demonstrates how this will be achieved, and to ensure that the five guiding principles described above are reflected in its governance and leadership arrangements.
5	Transparent approaches to identifying and recruiting leaders, which promote equity of opportunity and a professionally and demographically diverse talent pipeline which reflects that community it serves.		

3. Functions and Definitions

The 10 agreed priority functions for C&CP system leadership

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Our functions will define what we principally need to focus on and deliver at system level in south east London as a community of clinical and care professional leaders, if we are to maximise our impact and ensure that the system best serves our population. Some of these functions will be prescribed as statutory responsibilities are confirmed for the ICS, but the prioritisation of others will need to be shaped by us. All of our functions as an ICS will need to be delivered collaboratively and must compliment responsibilities held by leaders in places, Boroughs and individual organisations

Population health outcomes/inequalities	The effective use of information to build a learning health and care system that allocates resources fairly and optimally and delivers better and more equitable outcomes for South East Londoners.
Care pathway transformation/ innovation	The codesign of new models of care with care service commissioners, managers and service users that have a positive impact on clinical outcomes, cost reduction, patient satisfaction and teamwork and process outcomes.
System-wide clinical and care strategy	The setting out and clear communication of how the system will provide the best possible health and care outcomes for South East Londoners, working together with other systems to translate national priorities into the local context.
Workforce resilience	The creation of conditions that prioritise equality, diversity and inclusion, empower colleagues working across the system to reach their full potential and support their wellbeing, psychological safety, productivity, motivation and adaptability.
Quality Assurance and Safety	Continuous improvement of patient safety and care quality to meet statutory requirements and give confidence to Board, external regulators and the public.

The 10 agreed priority functions for C&CP system leadership

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These functions were identified and agreed at a workshop with a community of SEL clinical and care professional systems leaders. It was agreed that any governance model needed to be designed in order to most effectively support systems leadership of these function. **These ten functions will be delivered through clinical and care professional leadership capacity distributed across the ICS Governance, Transformation/Change Boards, Partnership Arrangements, and Clinical Networks**

Patient and public engagement	The active involvement in and championing of patient and public engagement to ensure that insights drawn from meaningful engagement inform work to improve and transform services across the system.
Continuous improvement and innovation	The systematic, sustainable and ongoing improvement of care processes and outcomes for patients, underpinned by a clear improvement and transformation methodology that reflects the complex nature of the system.
Professional leadership support and development	The development of continuous, collaborative and sustainable approaches that equip colleagues across the system with the knowledge, skills, perspectives and agency to deliver and improve systems of health care provision into the future.
Leadership in research & evidence creation, discovery and spread	The creation of a culture of innovation that actively encourages research and evidence generation, advocates for data-driven improvement and creates opportunities to collaborate, test, capture and share learning across the system.
Care standards	The development and implementation of agreed care standards alongside ongoing benchmarking/monitoring to ensure these are resulting in a reduction in variation of health and care outcomes - that reflect both national requirements and local population needs, and draws on the latest clinical and operational evidence.

4. Forms to support functions

Integrating Clinical and Care Professional system leadership into all areas of ICS System-level Governance arrangements

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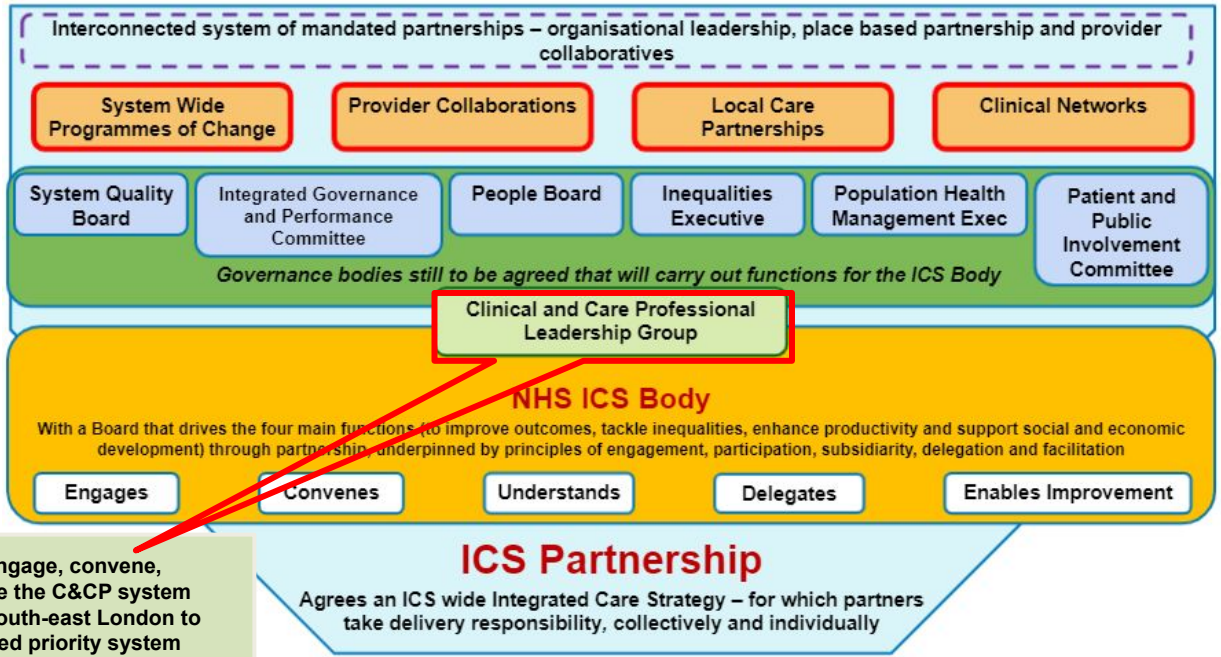

Newly formed group set up to engage, convene, understand, delegate and enable the C&CP system leadership community across south-east London to successfully deliver the 10 agreed priority system leadership functions. Empowered through blended CCP and Exec leadership. Will reflect the NHS Body commitment to Engage, Convene, Understand, Delegate and Enable Improvement in its operation. (See Slide 26 for more on C&CPLG).

FOR ILLUSTRATION ONLY - STILL IN DEVELOPMENT

Integrating Clinical and Care Professional system leadership into all areas of ICS System-level Governance arrangements

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C&CP system leadership integrated via leadership of and representation on all Care Pathway Transformation/ Change Boards - as well as clinical and care professional involvement in implementing change

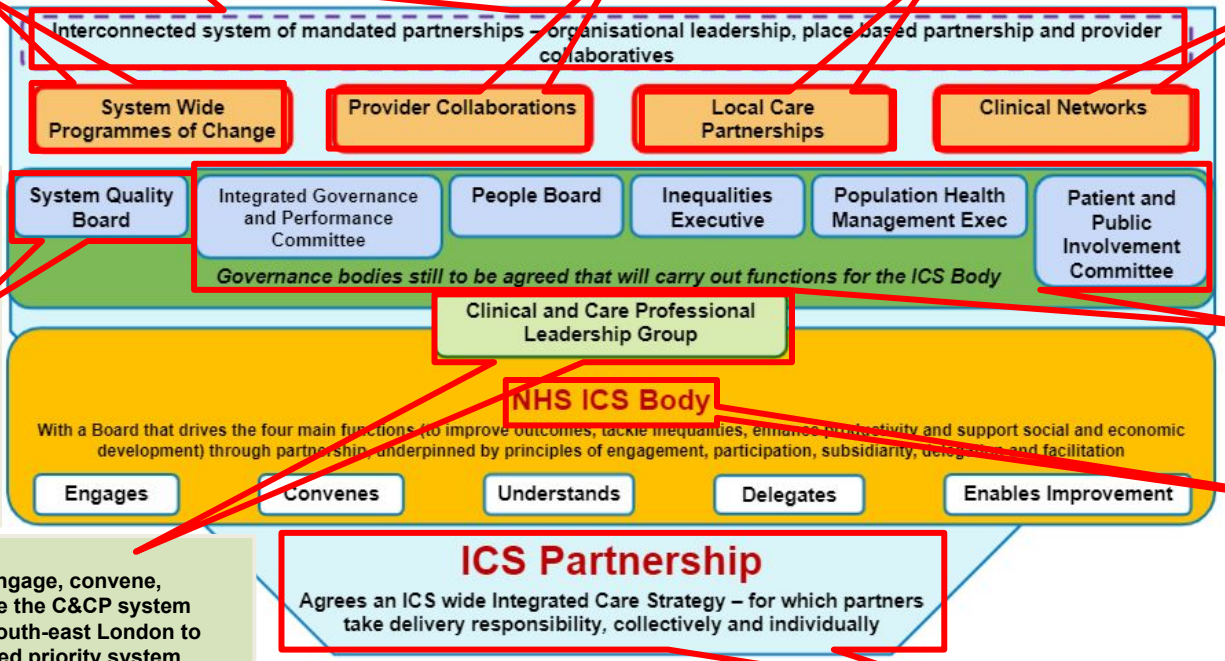
Organisational CCPL with development and support available to step into systems leadership roles

C&CP system leadership integrated via leadership of and/or representation on all Provider Collaborations

C&CP system leadership integrated via leadership of and/or representation on all LCP governance arrangements

Led by Clinical and Care Professionals with executive and management support. As an extension of this we anticipate the C&CPLG reviewing how we best engage and develop professional networks across our system including new networks for groups like AHPs and Community Pharmacists.

C&CP leadership integrated via appointed roles to be developed and defined by the CNO who will also Co-Chair. To fulfil the statutory responsibilities there will need to be a number of roles resourced across partner organisations, reporting for this will be into the System Quality Board and IGPG.



C&CP system leadership integrated via representation on all Committees, Groups, Executives and Boards.

Newly formed group set up to engage, convene, understand, delegate and enable the C&CP system leadership community across south-east London to successfully deliver the 10 agreed priority system leadership functions. Empowered through blended CCP and Exec leadership. Will reflect the NHS Body commitment to Engage, Convene, Understand, Delegate and Enable Improvement in its operation.

C&CP system leadership integrated via attendance by CMO, CNO.

C&CP system leadership integrated via appointed Executive roles (CMO and CNO) as well as partnership representation e.g. primary care.

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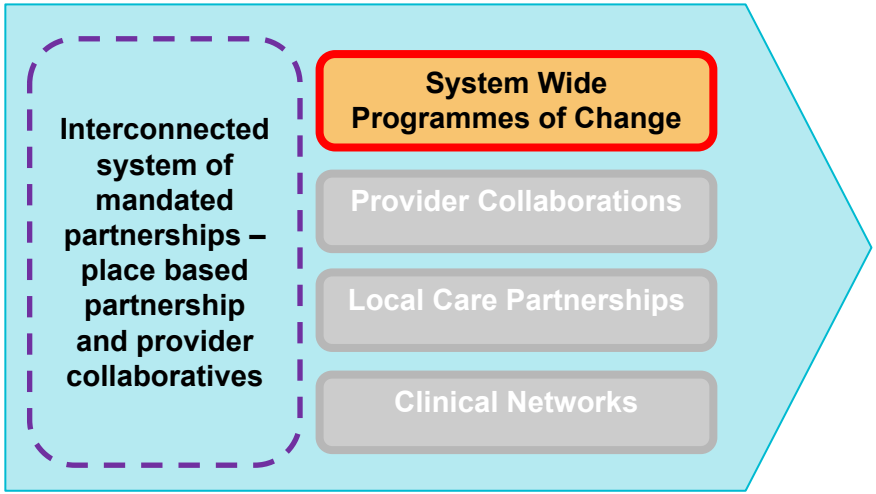
Integrating Clinical and Care Professional system leadership across the ICS

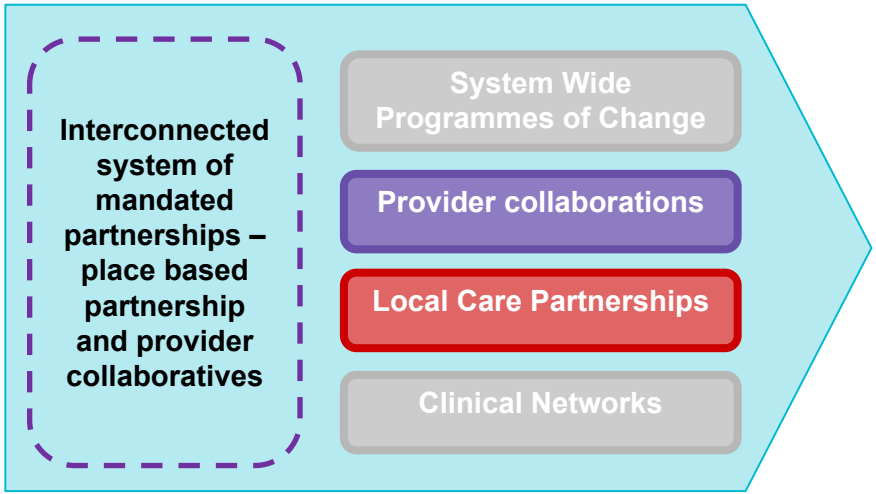
Transformation/Change Boards



- Urgent Care inc. 999/111 and ICS IUC/UEC pathways
- Cancer Alliance (inc ODN)
- Primary and Community Care inc. Care Homes
- Long term Conditions - Diabetes & Obesity
- Learning Disability and Autism
- Personalisation inc. social prescribing
- Estates/infrastructure
- Mental Health
- Planned Care
- Diagnostics
- Maternity Local System
- Children and Young People (inc ODN)
- Medicines Optimisation
- Digital (including infrastructure and enabling technology e.g remote monitoring)

Integrating Clinical and Care Professional system leadership across the ICS

Local Partnerships and Provider Collaborations



- Acute Provider Collaborative
- Mental Health Provider Collaborative
- Community Provider Network
- Primary Care Leadership Group

- Bexley Local Care Partnership
- Bromley Local Care Partnership
- Greenwich Local Care Partnership
- Lambeth Local Care Partnership
- Lewisham Local Care Partnership
- Southwark Local Care Partnership

Integrating Clinical and Care Professional system leadership across the ICS

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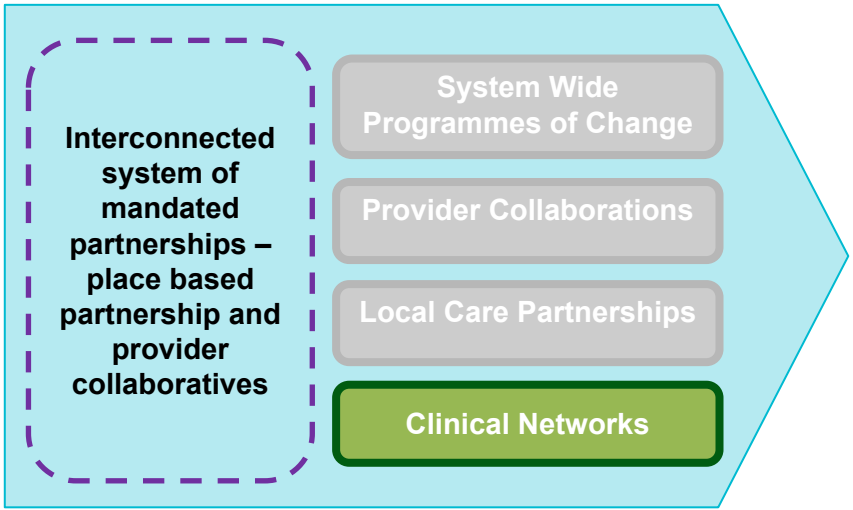
Clinical (and Professional*) Networks



**As an extension of this we anticipate the C&CPLG reviewing how we best engage, support and develop Professional Networks across our system including new networks for groups like AHPs and Community Pharmacists. We would see the proposed Academy 'Community of Practice' programme supporting such networks in it's work.*

Cardiovascular disease (inc. interface regional network and ODN)	General Surgery
Dementia (inc. interface regional network)	Gynaecology
Diabetes (inc. interface regional network)	Homeless Health
End of Life Care (inc. interface regional network)	Safeguarding
Frailty (inc. interface regional network)	IPC
Maternity (inc. interface regional network)	MSK and orthopaedics
Adult Mental Health (inc. interface regional network)	Neurology - epilepsy, headache etc (inc interface with ODN)
Respiratory and Long Covid (inc. interface regional network)	Neurosurgery (specialised ODN)
Stroke inc. community neurorehabilitation (inc. interface regional network)	Emergency (inc. trauma, burns and ICU ODN)
Cancer	Ophthalmology
Learning disability and autism	Chronic pain
CYP	Renal (inc. ODN/specialised network)
Dermatology	Personalisation
Diagnostics	Rheumatology
Digital	Urgent care inc. UEC/IUC
ENT	HIV
Gastroenterology & Endoscopy	Dental
	Urology

The following illustrates how we will locate and resource Clinical and Care Professional system leadership capacity

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The allocation of this system leadership capacity in relation to these 10 functions will be distributed across every spatial level of our partnership arrangements in a way that:

- Reflects our 'system of systems' approach
- Is agnostic of particular profession, place or provider organisation
- Is proportionate to the capacity necessary to ensure influence and impact in the design and delivery of care
- Ensures we recruit in a way that enhances diversity, inclusivity, innovation, and energy.

Locating our paid for and protected clinical and care professional system leadership resource - *a spatial view*

This model illustrates *where* we propose that clinical and care professional system leadership time is paid for, protected and prioritised within a new ICS Governance model in order to successfully deliver the ten priority functions.

It demonstrates that we will need to invest in and enable leadership in every part of the system, the depth of each wedge reflects where we propose C&CP system leadership in our new Governance model is drawn from i.e. resourced, protected and supported across 4 'spaces':

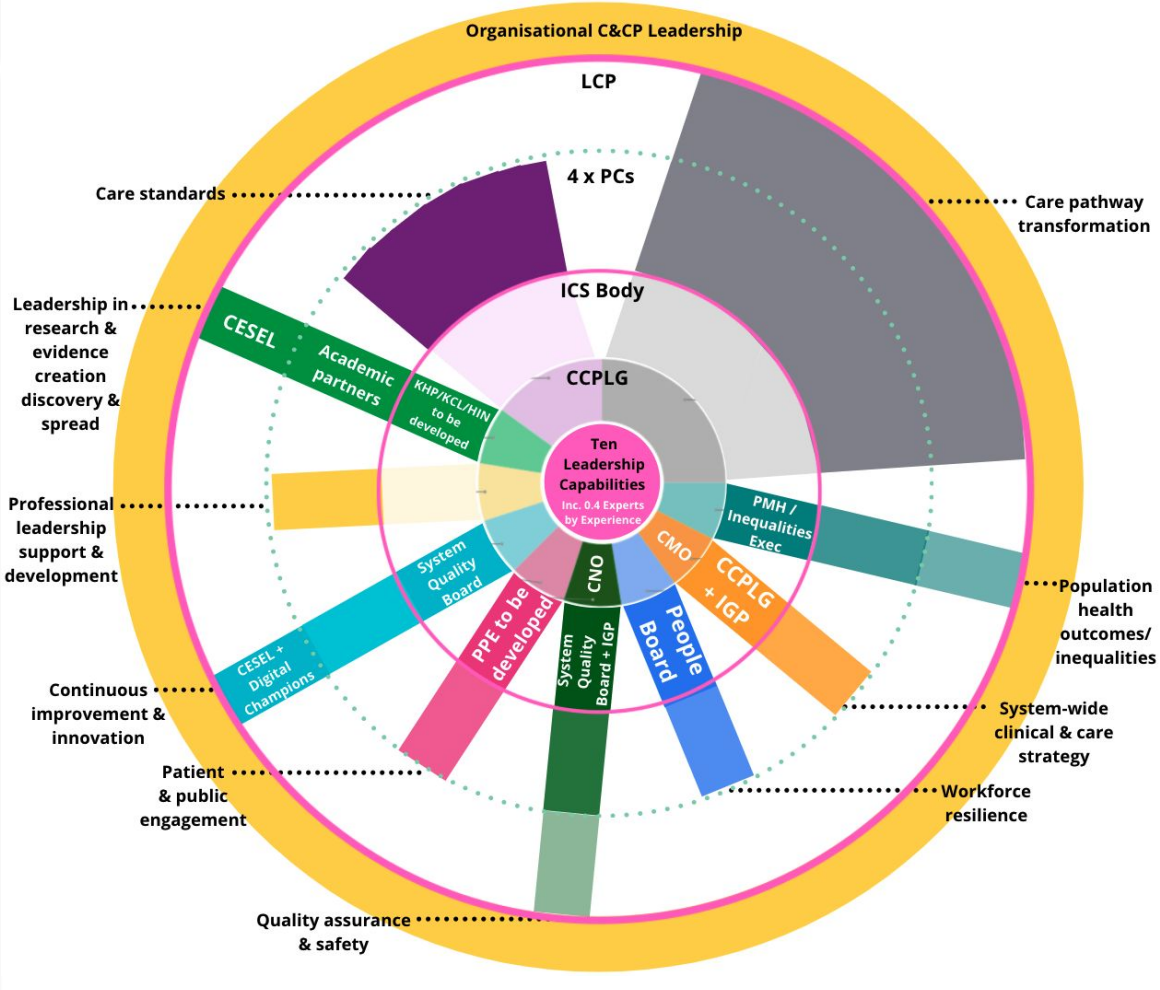
- Local Care Partnerships
- Provider collaborative arrangements/collaborations (PCs) - Acute, Mental Health, Community, and Primary Care
- ICS body
- Clinical and Care Professional leadership Group.

It also recognises a '5th space' i.e. organisational leadership including PCNs, where system leadership will continue to be vital but there are existing Governance and resourcing arrangements in place.

What you will see is that some functions will require investment in leadership in every space e.g. Care Pathway Transformation while others, such as providing 'Professional leadership support and development' can be resourced largely within the ICS in service of the wider community of leaders in other spaces. The intention to invest in supporting C&CP system leadership drawn from across our provider collaborations to support the development and in implementation of Care Standards (via Clinical Networks) in partnership with other ICSs via regional clinical networks to ensure more consistent care quality is also reflected.

The model does not attempt to reflect where the work associated with each of our ten proposed priority functions gets done, or the full extent of clinical and care professional capacity necessary to support organisational and system change. This will continue to benefit from the full engagement and involvement of our extraordinary frontline workforce. However these are equally not simply oversight/governance roles - there is an expectation that all health and care professionals involved in system transformation will be 'hands-on' leaders, supporting change by promoting collaboration - in keeping with the 'Ways of Working' we are developing as an ICS.

The model has been designed to reflect the principles agreed for our approach to Governance by our community of C&CP leaders, in particular that we take a distributed approach to leadership.



The colour gradient of the functions at each spatial level reflects the scale of resource and investment

Lower resource — **Higher resource**

Locating our paid for and protected clinical and care professional system leadership resource - *a proportionate investment view*

This version of the model provides a comparative view of how we expect our overall investment in clinical and care professional system leadership will be *distributed* proportionately across the ten functions. Here, the 'thickness' of each wedge represents the scale of investment in C&CP system leadership roles and time broadly expected per function as a proportion of overall spend.

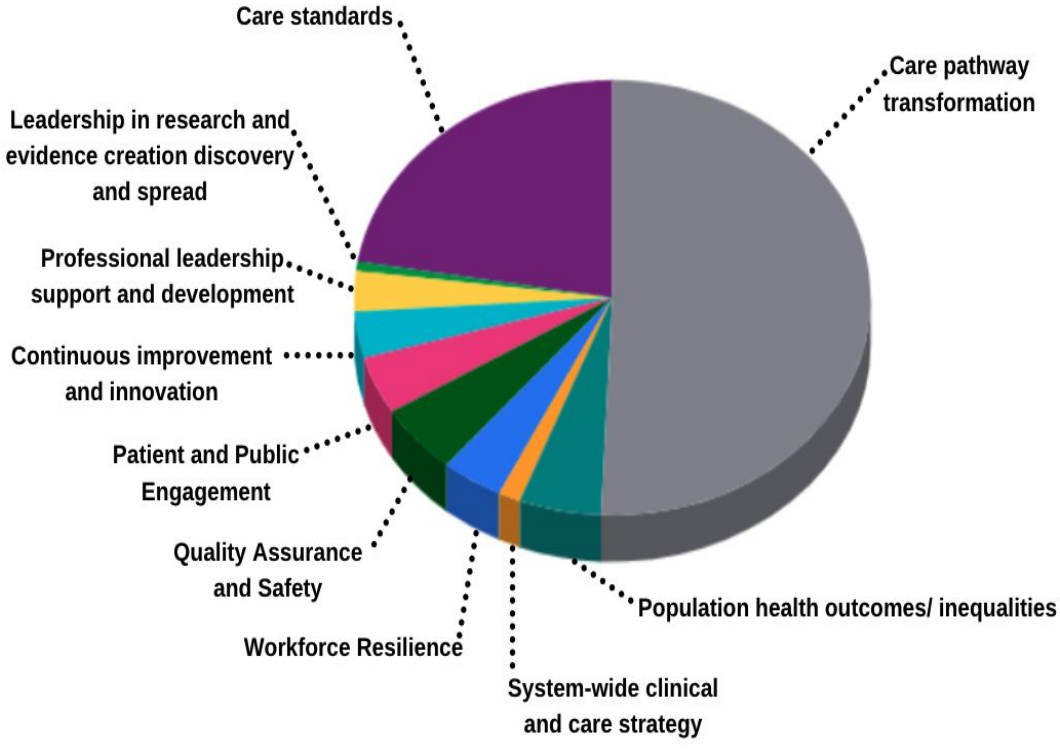
What this reflects is that we expect:

- over 50% of our investment will be to support clinical and care professional system leadership across our care pathway transformation programmes and boards
- Almost 25% of our investment will be to support clinical and care professional system leadership across our clinical networks
- The remaining investment will be spread across the other 7 functions with an emphasis on Population Health and Quality Assurance and Safety, reflecting the primacy of these issues for the system and clinical and care professional leaders.

This further reflects the principles agreed for governance of clinical and care professional systems leadership that we will invest and support a model of distributed leadership, enabling our workforce to design and deliver services where that is most efficient and effective.

It also reflects our commitment to design governance for C&CP system leadership that supports the ICS' overarching strategy - at the core of which is the design and delivery of exceptional care - both services and standards. By deliberately investing in these two functions we recognise those priorities.

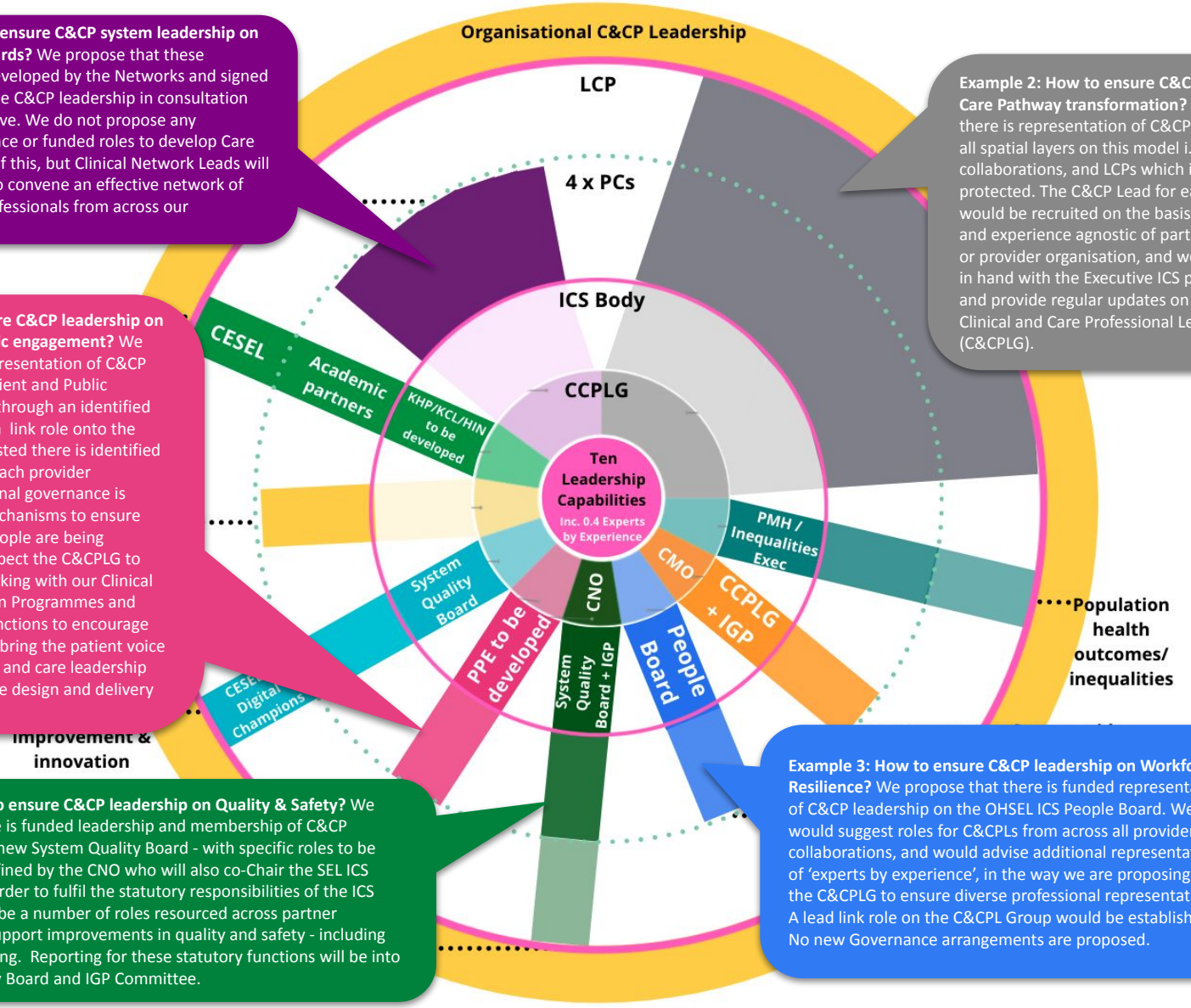
This strengthens the case for investing in our south east London system leadership Academy with a priority focus on supporting our clinical network and care pathway transformation leader cohorts. In doing so we maximise the value of investing in these roles and associated protected time.



Example 1: How to ensure C&CP system leadership on system Care Standards? We propose that these standards will be developed by the Networks and signed off by a subset of the C&CP leadership in consultation with the ICS Executive. We do not propose any additional governance or funded roles to develop Care Standards outside of this, but Clinical Network Leads will have funded time to convene an effective network of health and care professionals from across our partnership.

Example 2: How to ensure C&CP leadership on Care Pathway transformation? We propose that there is representation of C&CP leadership from all spatial layers on this model i.e. ICS, provider collaborations, and LCPs which is paid for and protected. The C&CP Lead for each programme would be recruited on the basis of their expertise and experience agnostic of particular profession or provider organisation, and would work hand in hand with the Executive ICS programme lead and provide regular updates on progress to the Clinical and Care Professional Leadership Group (C&CPLG).

Example 5: How to ensure C&CP leadership on system patient and public engagement? We propose that there is representation of C&CP leadership on the ICS Patient and Public Involvement committee through an identified C&CP Lead, to establish a link role onto the C&CPL Group. It is suggested there is identified C&CPL PPE capacity for each provider collaboration. No additional governance is proposed but further mechanisms to ensure accountability to local people are being developed. We would expect the C&CPLG to take an active role in working with our Clinical Networks, Transformation Programmes and across all of the other functions to encourage good practice in how we bring the patient voice together with the clinical and care leadership voice for best effect in the design and delivery of services.



Example 4: How to ensure C&CP leadership on Quality & Safety? We propose that there is funded leadership and membership of C&CP leadership on the new System Quality Board - with specific roles to be developed and defined by the CNO who will also co-Chair the SEL ICS C&CPL Group. In order to fulfil the statutory responsibilities of the ICS there will need to be a number of roles resourced across partner organisations to support improvements in quality and safety - including IPC and safeguarding. Reporting for these statutory functions will be into the System Quality Board and IGP Committee.

Example 3: How to ensure C&CP leadership on Workforce Resilience? We propose that there is funded representation of C&CP leadership on the OHSEL ICS People Board. We would suggest roles for C&CPLs from across all provider collaborations, and would advise additional representation of 'experts by experience', in the way we are proposing for the C&CPLG to ensure diverse professional representation. A lead link role on the C&CPL Group would be established. No new Governance arrangements are proposed.

How we propose to develop the **new** Clinical and Care Professional Leadership Group

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The ICS Clinical and Care Professional Leadership Group will be refreshed to reflect these agreed functions and statutory responsibilities. It will have additional representation to reflect integration between providers, professional diversity through the inclusion of 'experts by experience', ICS Executive leadership to enable decision making authority in relation to agreed functions, and work in a way that reflects our commitments as a partnership

Capability 1: Leadership in ICS statutory responsibilities via ICS Governance:

- CMO (Co-chair)
- Integrated Governance and Performance Committee lead
- Patient and Public Involvement Committee lead
- People Board lead
- PHM & Inequalities Executive lead

Capability 2: Leadership in service design and delivery:

- Mental Health Provider Collaborative
- Acute Provider Collaborative
- Community Care Collaborative
- Primary Care Leadership Group/Collaborative

Capability 3: Leadership in Quality and Safety (direct statutory responsibility) via System Quality Board

- CNO (Co-chair)

Capability 4: Leadership in the development and support of C&CP system leadership development and support

- System leadership development & support link

Capability 5: Leadership in transformation, innovation and improvement:

- Transformation and improvement link

Capability 6: Clinical Networks, transformation and enabling programmes invited on ad-hoc basis

Capability 7: Experts by experience in:

- Local Authority
- Care Sector
- Community Pharmacy
- HIN
- AHPs
- Dentistry
- CYP
- HEE
- VSCE
- KHP
- Public Health
- Digital
- Optometry

Capability 8: Continuous improvement and innovation

Capability 9: Leadership in research and evidence creation discovery and spread

Capability 10: Executive leadership and decision making responsibilities

Proposed principles for the new Clinical and Care Professional Leadership Group

Our Healthier South East London
Integrated Care System

Design Principles

The Group has been designed to reflect the six principles agreed for this design effort by our community of C&CP leaders i.e.

- C&CP leadership is integrated and interdependent with Exec and managerial leaders
- It supports the delivery of the ICS strategy
- Focuses our resources on areas where system leadership can have most impact
- Is inclusive in every way
- Is supportive of system leadership development
- Is focused on learning.

Working Principles

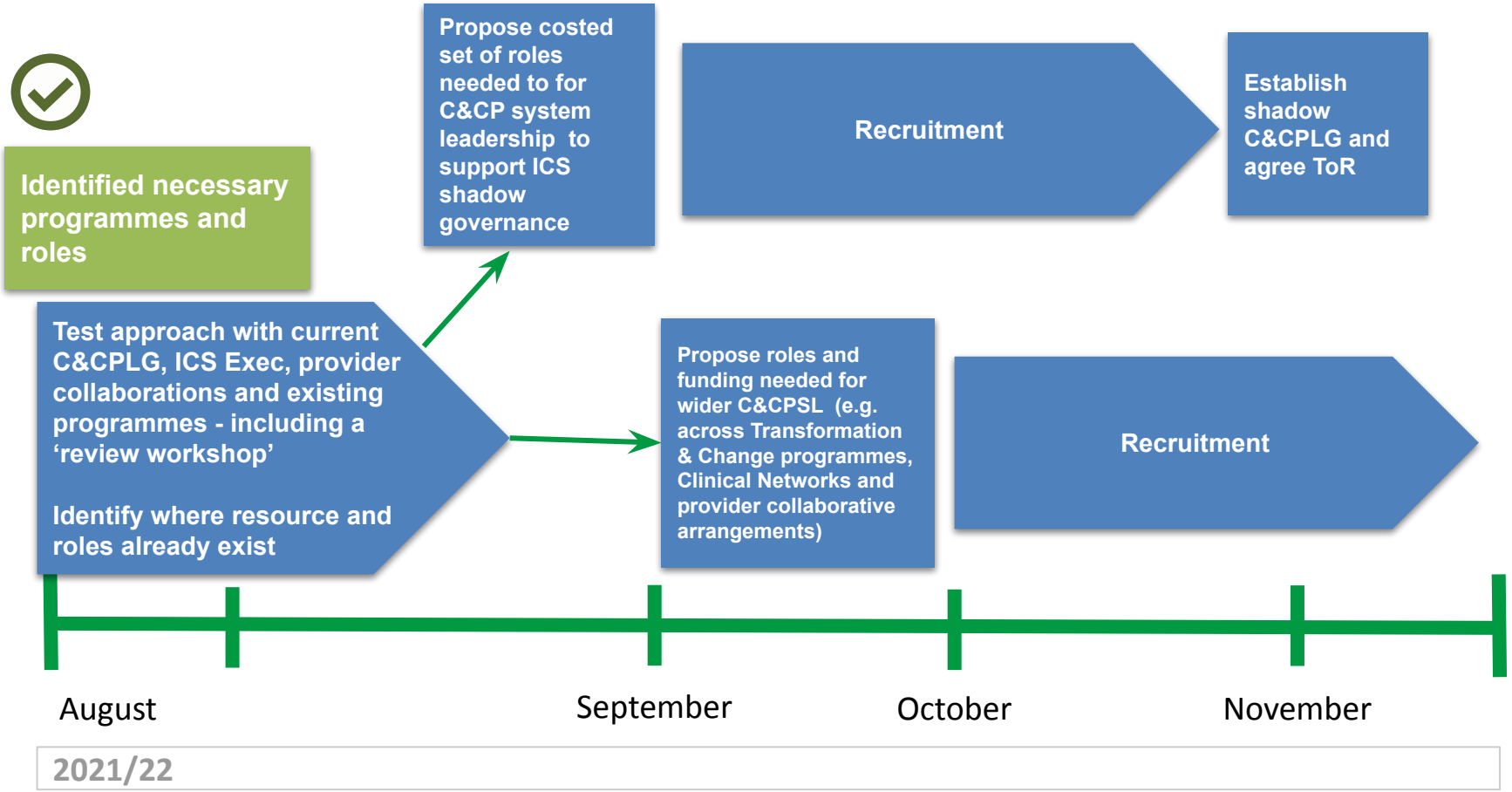
The Clinical and Care Professional Leadership Group will:

- Work in a spirit of kindness, curiosity and joy
- Work in collaborative, systemic ways as an exemplar to our colleagues and teams
- Organise its agendas and attention around the 10 agreed functions for C&CP system leadership
- Be action not update oriented
- Create spaces where all voices are heard
- Promote and model transparency in all its work
- Aspire to be the last commitment any member would consider removing from their diaries
- Commit to evolving from a C&CP system leadership group, to a system leadership team, to sparking a system leadership movement across south east London.
- The ask of Members is to live these principles. The offer in return is that they will be supported to develop skills in system leadership.

5. ICS Exec Questions & Forward Plan

Our high level forward plan and next steps

Our Healthier South East London
Integrated Care System



Questions for the ICS Executive

Our Healthier South East London
Integrated Care System

"The ICS NHS board will be expected to sign off a model and improvement plan for clinical and care professional leadership that demonstrates how the ICS has developed a model of distributed clinical and care professional leadership, and a culture which actively encourages and supports such leadership to thrive. This includes ensuring professional and clinical leaders have protected time and resource to carry out system roles, and are fully involved as key decision-makers, with a central role in setting and implementing ICS strategy. And to ensure that the five guiding principles described are reflected in its governance and leadership arrangements."
NHSEI ICS Design Framework, 2021

Key questions

- **Have we ensured that what we are proposing reflects our local engagement, agreed purpose and principles as an ICS partnership and the NHSEI Design Framework?**
- **Does this provide a useful framework that demonstrates how resources could be allocated across the 10 priority functions for the C&CPL system leadership?**
- **How can we make sure the C&CPLG has the right balance of clinical & care professional and executive membership to be a decision making body?**
- **What further detail would the ICS Exec need to commit to invest in developing the capacity and capability proposed? And who else needs to be involved in getting us there?**

6. Annex

Illustrative examples describing the location, resourcing and governance proposed for C&CP system leadership in order to deliver each of the 10 functions

The following slides are illustrative examples depicting the how clinical and care professional system capability and capacity would be organised to best deliver each of the 10 functions. We plan to further develop and test this with a broader group of system leaders to ensure we have accurately captured governance, location, programme needs, and appropriate capacity for each function.

Supporting C&CP system leadership for care standards

- **What C&CP system leadership is required?**
  - Clinical Network Leads to participate in the development of regional care standards and assurance processes
- **Spatial areas where paid for resource and Governance is concentrated**
  - ICS
- **Existing Governance structures?**
  - OHSEL Clinical Programme Board
  - Differential levels of maturity and management support currently across clinical networks in SEL
- **New Governance structures needed?**
  - Care standards for implementation in SEL to come for approval to the C&CPLG
  - These are managed networks and need support to convene, review best practice, develop guidance/standards for the ICS and disseminate these – but do not need more formal governance
- **Where will C&CP leadership be drawn from?**
  - Leads recruited from all care providers, expected to have expertise in the network specialty, systems leadership development support provided
- **ICS paid role/protected time?**
  - Proposed 0.4 WTE for those in Network Lead positions
  - Associated management capacity drawn from ICS partners,systems leadership development support provided
- **Other spatial areas where protected time or roles will be required to assure the necessary C&CP System leadership to successfully deliver this function?**
  - Small amount of time from professionals across provider organisations and places with expertise to participate in network/community of practice, standards development
  - Clinical Networks support the development and implementation of care standards across ICS partner organisations

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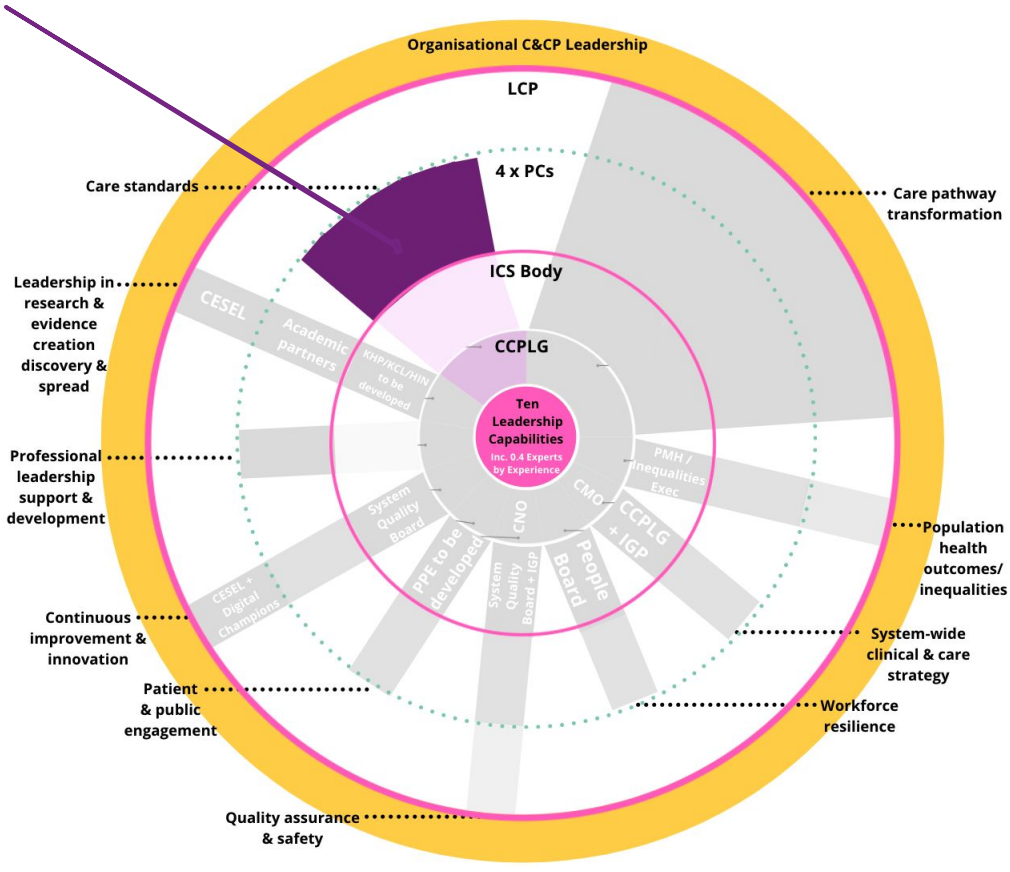
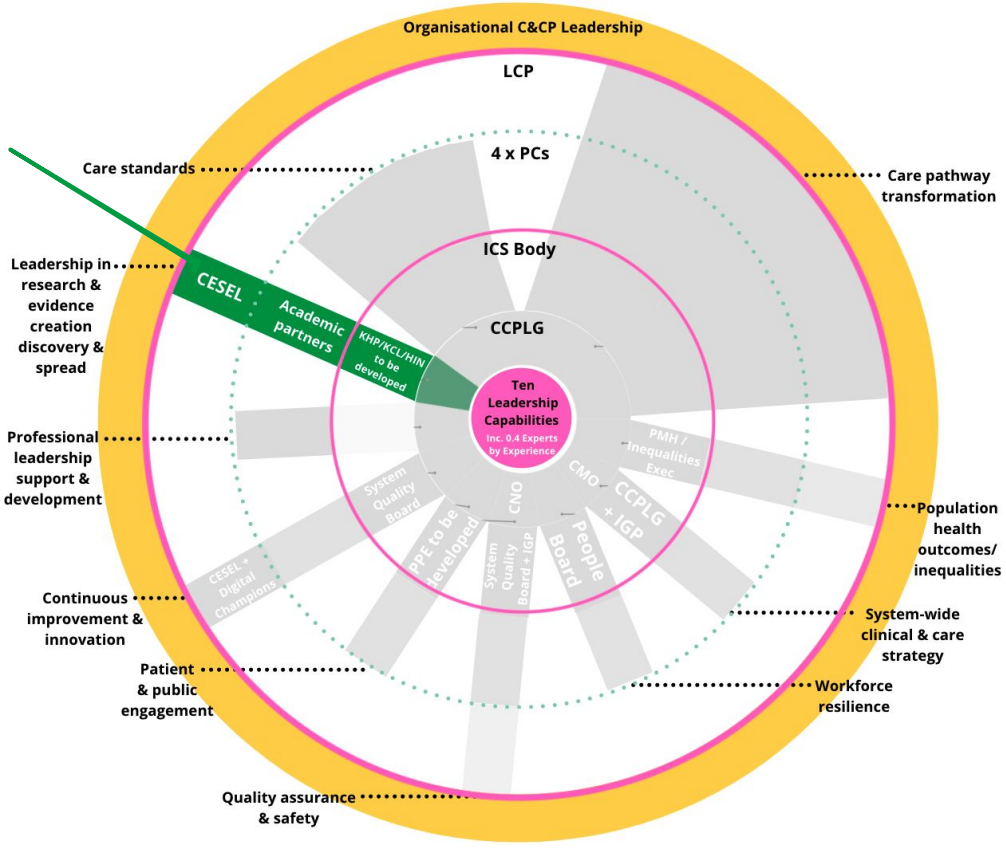


ILLUSTRATIVE DRAFT

Supporting C&CP system leadership for Leadership in research and evidence creation, discovery and spread

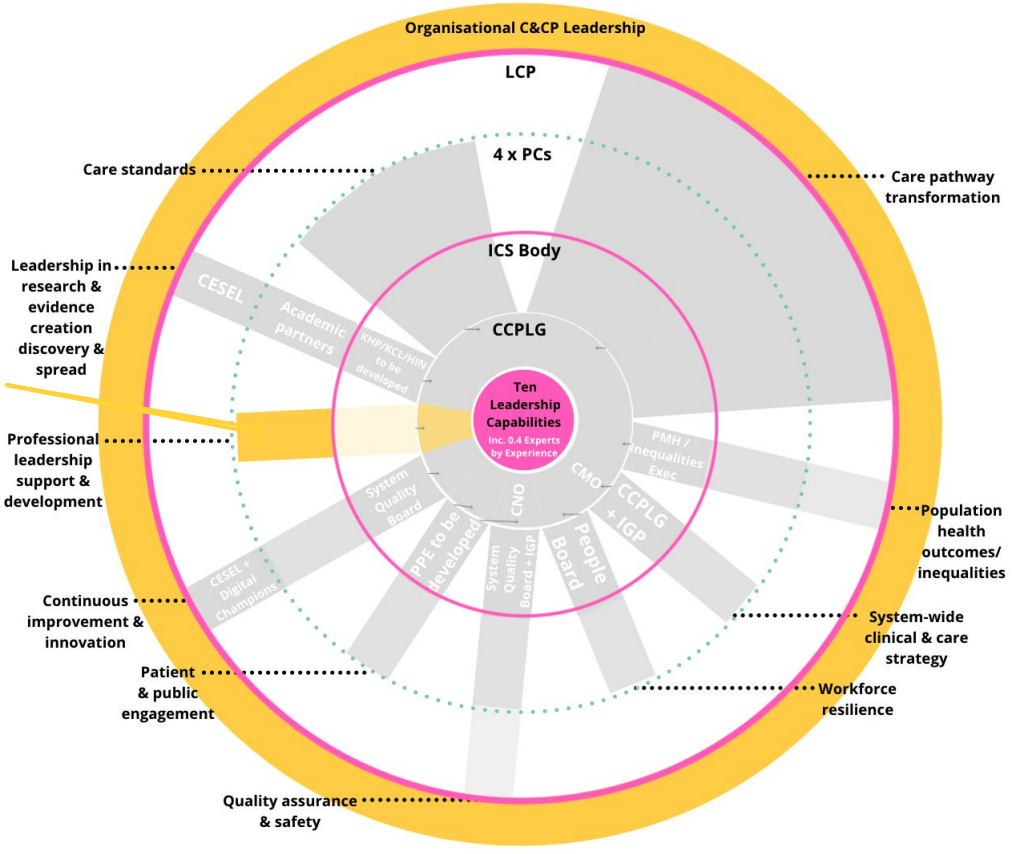
- **What C&CP system leadership is required?**
  - A joint C&CPL role with KHP/ARC
- **Spatial areas where paid for resource and Governance is concentrated**
  - ICS
- **Existing Governance structures?**
  - KHP Leadership Group
  - ARC Executive
- **New Governance structures needed?**
  - C&CPLG enabling representation between the ICS leadership and research partners
  - Digital and Data Programme Board
- **Where will C&CP leadership be drawn from?**
  - Clinical academic partners
- **ICS paid role/protected time?**
  - Proposed 0.4 WTE
- **Other spatial areas where protected time or roles will be required to assure the necessary C&CP System leadership to successfully deliver this function?**
  - Continued clinical and care professional leadership in CAGs, Real World Evidence generation, Institutes and front line services to support the development of a Learning Health System



ILLUSTRATIVE DRAFT

Supporting C&CP system leadership for Professional leadership development and support

- **What C&CP system leadership is required?**
  - C&CPL representation on the Advisory Board for the SEL systems leadership Academy
- **Spatial areas where paid for resource and Governance is concentrated**
  - ICS
- **Existing Governance structures?**
  - People Board
  - KHP Leadership Group
- **New Governance structures needed?**
  - C&CPLG
  - Advisory Board - Systems Leadership Academy
- **Where will C&CP leadership be drawn from?**
  - Lead recruited from all care providers, expected to have interest and experience in innovation, training and development, and systems leadership
- **ICS paid role/protected time?**
  - Proposed 0.4 WTE ICS role
  - Administrative support through Academy
- **Other spatial areas where protected time or roles will be required to assure the necessary C&CP System leadership to successfully deliver this function?**
  - Support for clinicians, care professionals, and managers to be released into systems leadership training and development programmes



Supporting C&CP system leadership for Continuous improvement and innovation

- **What C&CP system leadership is required?**
  - A joint C&CPL role with KHP/HIN
  - Digital leadership - CCIO, CSO
  - CESEL Leads
- **Spatial areas where paid for resource and Governance is concentrated**
  - ICS, Provider Collaborations, LCPs
  - Boroughs - CESEL Leads, Digital Champions
  - Clinical Networks and pathway transformation programmes
- **Existing Governance structures?**
  - CESEL Steering Group
  - Digital First Programme Board
  - Clinical Networks and Transformation Programme Boards
- **New Governance structures needed?**
  - System Quality Board
  - Digital and Data Programme Board
  - Remote Monitoring Network
- **Where will C&CP leadership be drawn from?**
  - Leads recruited from all care providers, expected to have interest in improvement and innovation, systems leadership development support provided
- **ICS paid role/protected time?**
  - Proposed 0.4 WTE ICS role, 0.2 role for each provider collaboration
  - Administrative support through KHP, digital programmes, CESEL
- **Other spatial areas where protected time or roles will be required to assure the necessary C&CP System leadership to successfully deliver this function?**
  - This function will be delivered in a very distributed way through individual organisations, change programmes, and clinical networks - the system level roles are principally about establishing the necessary enabling capability, theory of change, systematic improvement method, training and development support

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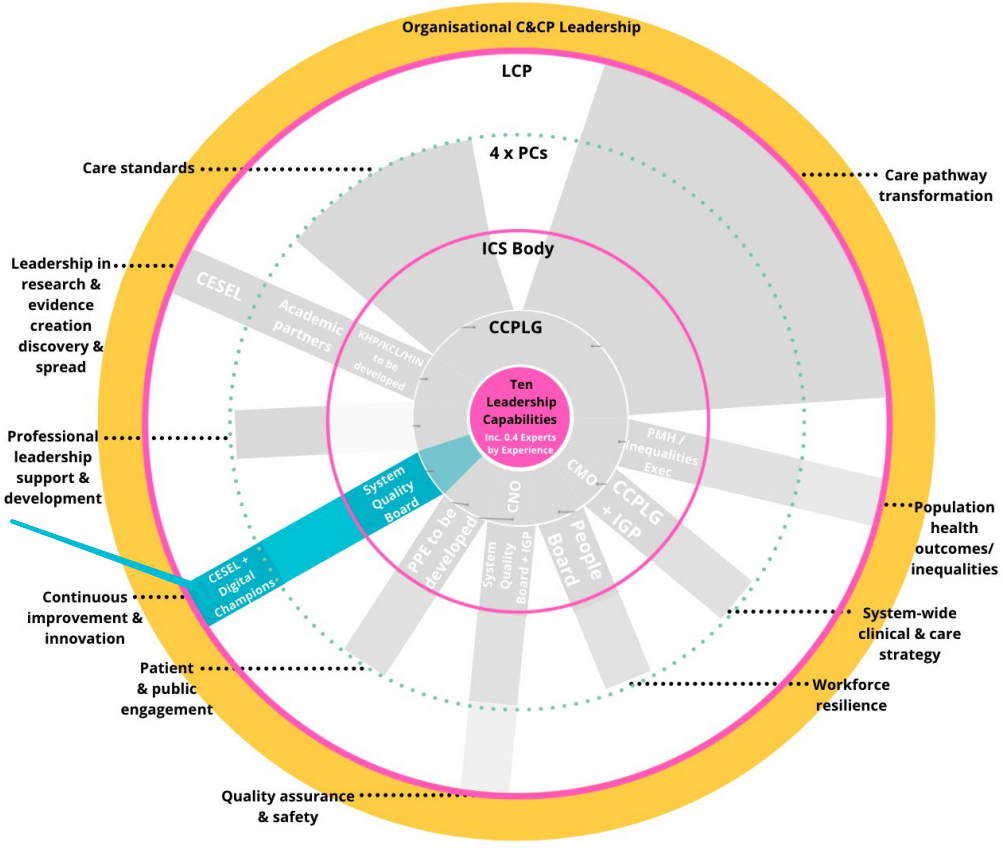
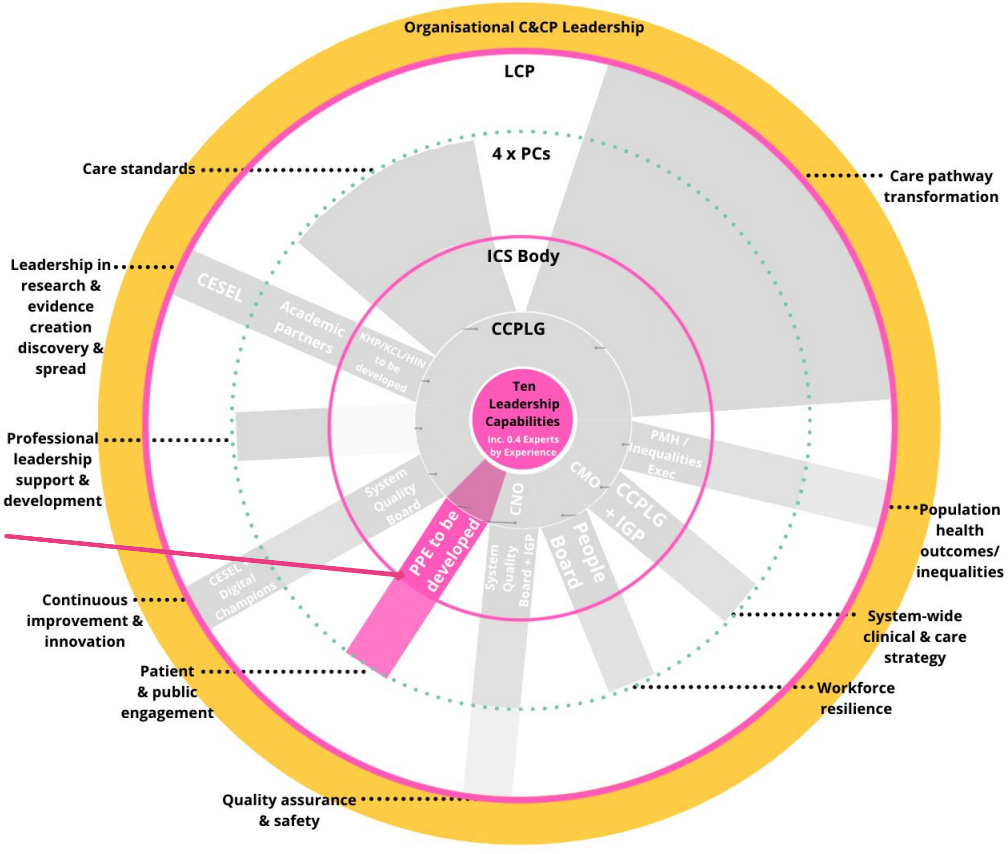


ILLUSTRATIVE DRAFT

Supporting C&CP system leadership for Patient & public engagement

- **What C&CP system leadership is required?**
  - C&CPL representation on the ICS Patient and Public Involvement Committee
- **Spatial areas where paid for resource and Governance is concentrated**
  - ICS and provider collaborations
- **Existing Governance structures?**
  - CCG PPE governance at sector and borough level
  - Provider organisational arrangements
  - Local Authority public engagement processes
- **New Governance structures needed?**
  - ICS Patient and Public Involvement Committee
  - Additional accountability to local people TBD
- **Where will C&CP leadership be drawn from?**
  - Leads recruited from all care providers, expected to have interest in patient and public voice, systems leadership development support provided
- **ICS paid role/protected time?**
  - Proposed 0.4 WTE ICS role, 0.2 role for each provider collaboration
  - Administrative support to be provided through the ICS PPE team
- **Other spatial areas where protected time or roles will be required to assure the necessary C&CP System leadership to successfully deliver this function?**
  - We would expect the C&CPLG to take an active role in working with our Clinical Networks, Transformation Programmes and across all of the other functions to encourage good practice in how we bring the patient voice together with the clinical and care leadership voice for best effect in the design and delivery of services.



Supporting C&CP system leadership for Quality assurance and safety

- **What C&CP system leadership is required?**
  - CNO
  - IPC Lead
  - Safeguarding Lead
  - Further guidance in relation to statutory roles awaited
- **Spatial areas where paid for resource and Governance is concentrated**
  - ICS
- **Existing Governance structures?**
  - CCG Quality and Safety Committee
  - CCG IGP
  - Provider CQRG
  - Safeguarding network
  - Quality Alerts
- **New Governance structures needed?**
  - System Quality Board
  - ICS IGP Committee
- **Where will C&CP leadership be drawn from?**
  - CNO open recruitment
  - Other Quality Leads (TBC) recruited from all care providers, expected to have interest in quality improvement, systems leadership development support provided
- **ICS paid role/protected time?**
  - CNO - 1.0 WTE
  - Additional roles TBD
- **Other spatial areas where protected time or roles will be required to assure the necessary C&CP System leadership to successfully deliver this function?**
  - In order to fulfil the statutory responsibilities of the ICS there will need to be a number of roles resourced across partner organisations to support improvements in quality and safety - including IPC and safeguarding. Reporting for these statutory functions will be into the System Quality Board and IGP Committee.

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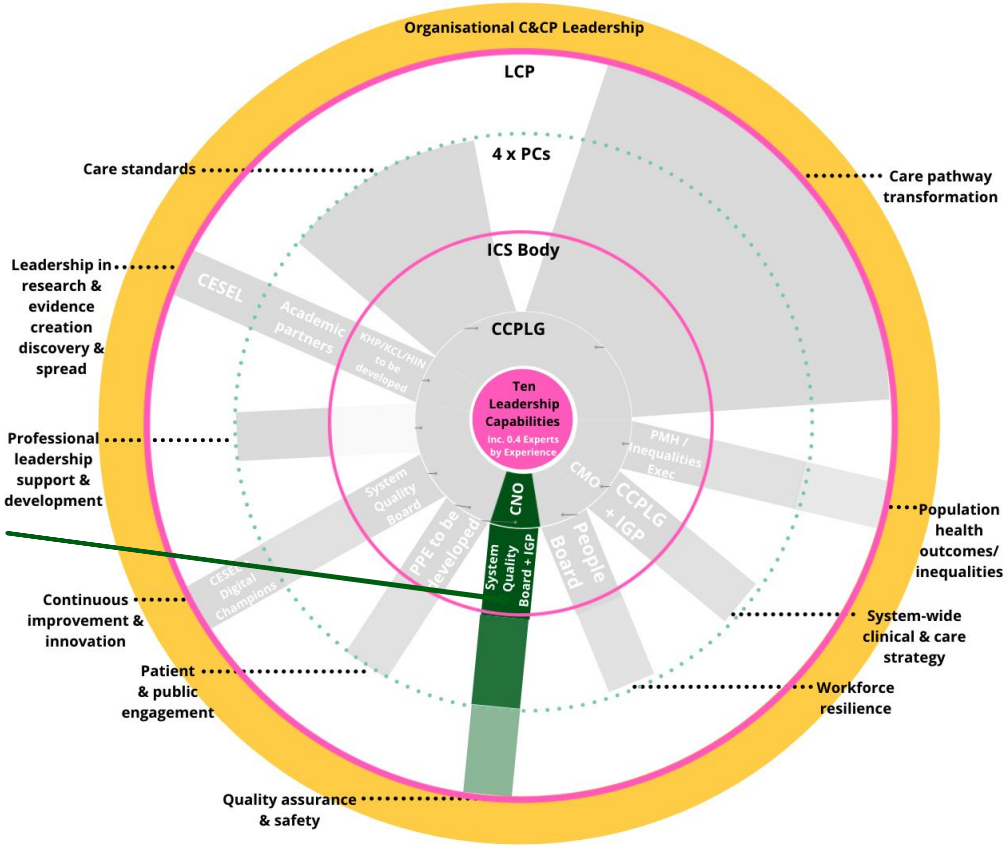

Supporting C&CP system leadership for Workforce resilience

- **What C&CP system leadership is required?**
  - C&CPL representation on the Advisory Board for the SEL systems leadership Academy
  - C&CPL on the People Board
  - HEE representation on the C&CPLG
- **Spatial areas where paid for resource and Governance is concentrated**
  - ICS, provider collaborations, and LCPs
- **Existing Governance structures?**
  - People Board
  - HEE
  - Borough training hubs
- **New Governance structures needed?**
  - C&CPLG
  - Workforce development network
- **Where will C&CP leadership be drawn from?**
  - Leads recruited from all care providers, expected to have interest in workforce wellbeing, training and development, systems leadership development support provided
- **ICS paid role/protected time?**
  - Proposed 0.4 WTE ICS role, 0.2 WTE role for each provider collaboration, and 0.2 WTE in each LCP
  - Administrative support through workforce programme
- **Other spatial areas where protected time or roles will be required to assure the necessary C&CP System leadership to successfully deliver this function?**
  - Support for clinicians and care professionals, and managers to be released training and development programmes
  - Involvement of organisational training and development leads to help determine and shared resources/support

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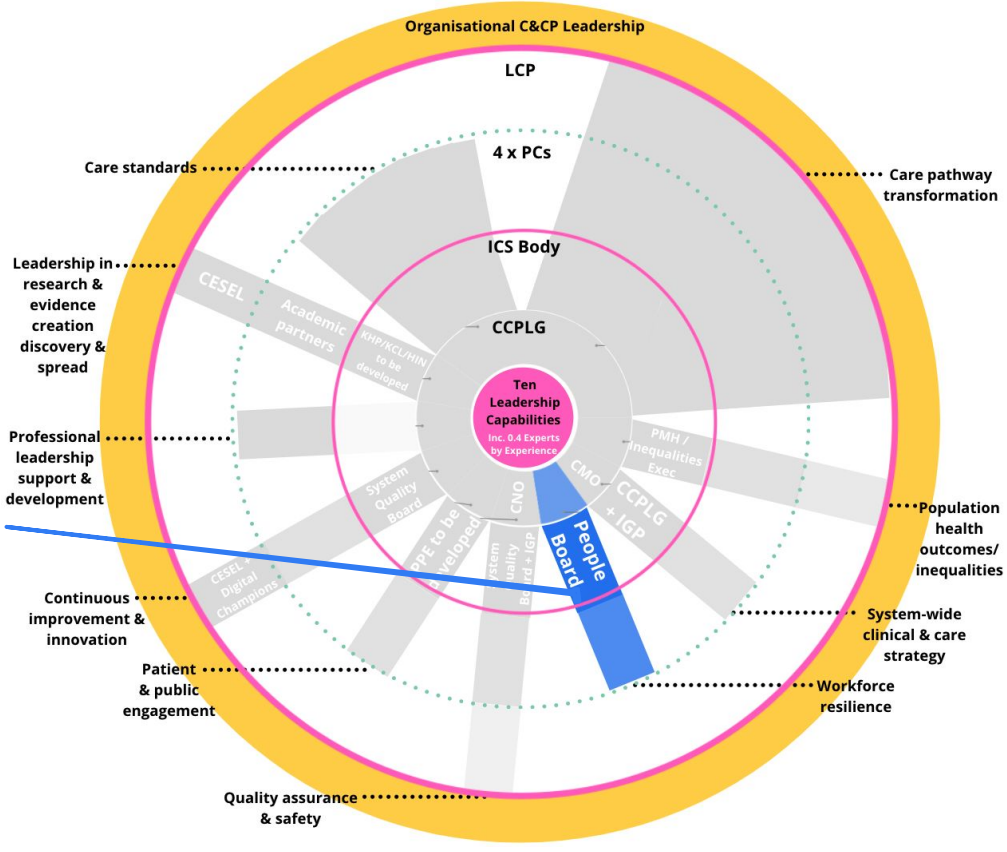

Supporting C&CP system leadership for System wide clinical and care strategy

- **What C&CP system leadership is required?**
  - CMO
  - Provider collaboration Clinical Lead
  - LCP Clinical Lead
- **Spatial areas where paid for resource and Governance is concentrated**
  - ICS, Provider collaborations, and LCPs
- **Existing Governance structures?**
  - OHSEL Clinical Programme Board
  - CCG Governing Body/CSC
- **New Governance structures needed?**
  - C&CPLG
  - Integrated Care Board
- **Where will C&CP leadership be drawn from?**
  - CMO open recruitment
  - Other C&CP Leads identified through existing/future provider collaborative arrangements and LCP Boards. Recruitment from all care providers, expected to have interest and experience in systems leadership - development support provided
- **ICS paid role/protected time?**
  - CMO 1.0 WTE (TBC)
  - Provider Collaborations 0.2 WTE
  - LCP 0.2 WTE
- **Other spatial areas where protected time or roles will be required to assure the necessary C&CP System leadership to successfully deliver this function?**
  - MDs, CDs and other care professional leads from partner organisations will be actively involved in determining the ICS clinical strategy and priorities

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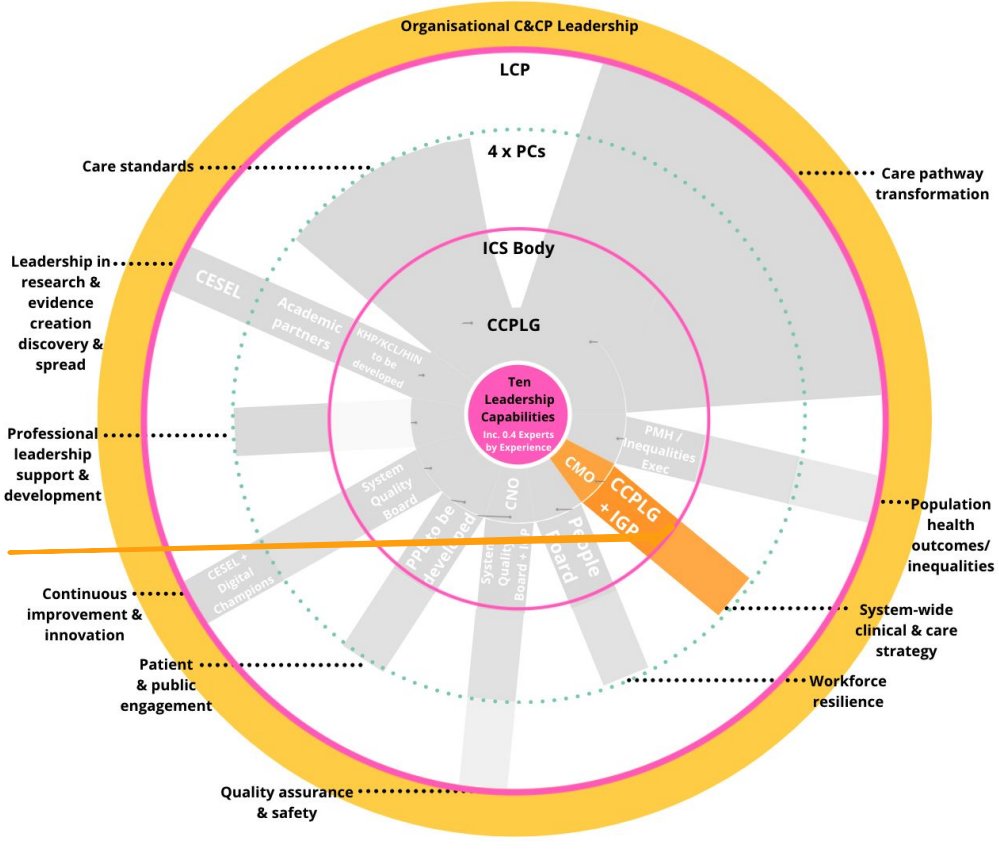

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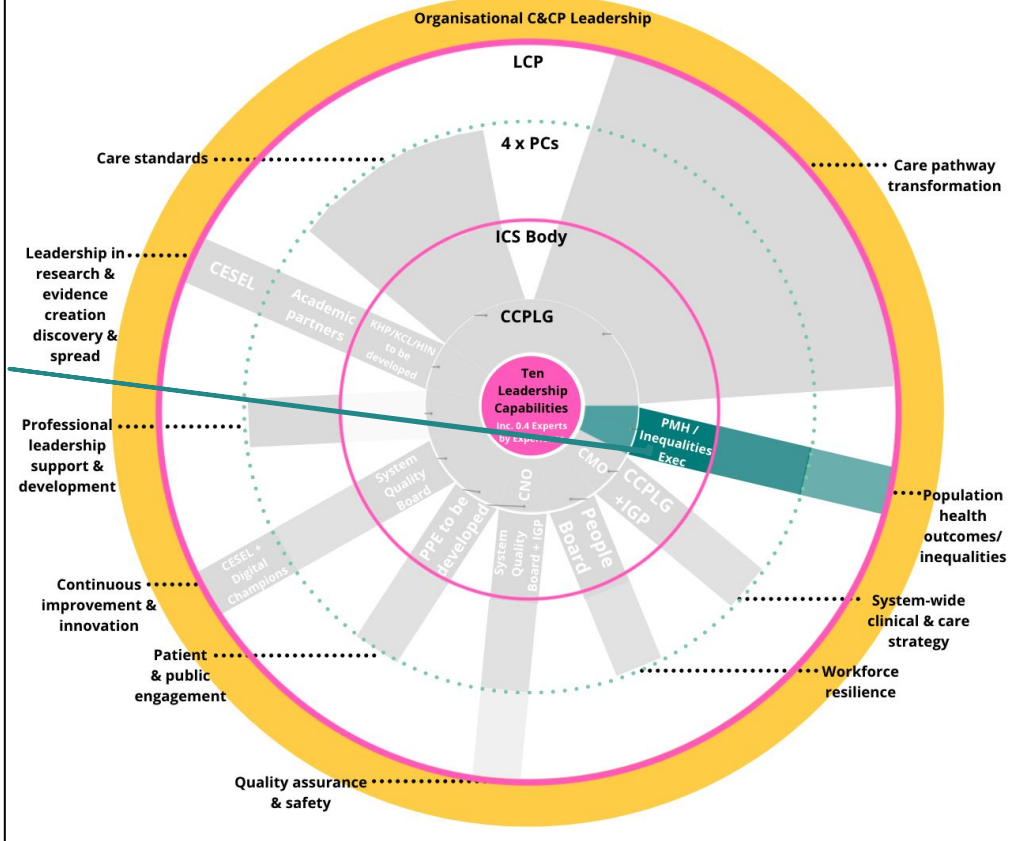
Supporting C&CP system leadership for Population health outcomes/inequalities

- **What C&CP system leadership is required?**
  - C&CP Lead for PHM, prevention and inequalities
  - DPH representative on C&CPLG
  - CCIO
- **Spatial areas where paid for resource and Governance is concentrated**
  - ICS, Provider collaborations, and LCPs
- **Existing Governance structures?**
  - ICS PHM and Inequalities Exec
- **New Governance structures needed?**
  - PHM enabling programme steering group
- **Where will C&CP leadership be drawn from?**
  - Leads recruited from all care providers, expected to have interest in PHM, data driven insights, proactive care, prevention, and value based interventions - development support provided
- **ICS paid role/protected time?**
  - Proposed 0.4 WTE ICS role, 0.2 WTE role for each provider collaboration, and 0.2 WTE in each LCP
  - Administrative support through PHM and Inequalities programme/KHP
- **Other spatial areas where protected time or roles will be required to assure the necessary C&CP System leadership to successfully deliver this function?**
  - PHM is an enabling programme requiring coordinated action to establish the necessary data infrastructure and analytics support to ensure Clinical and Care professional Leaders across the ICS have access to the insights they need to drive improvement, innovation, and care pathway transformation. This will require protected time for care professionals within organisations (including PCNs) and ICS transformation programmes



Supporting C&CP system leadership for Care pathway transformation

- **What C&CP system leadership is required?**
  - ICS Transformation Programme Clinical SROs
  - Provider collaborations and LCP C&CPL capacity identified for all key pathway transformation programmes
- **Spatial areas where paid for resource and Governance is concentrated**
  - ICS, provider collaborations, and LCPs
- **Existing Governance structures?**
  - OHSEL Clinical Programme Board
- **New Governance structures needed?**
  - C&CPLG
  - Effective programme governance/TPMO for all system-wide change programmes
- **Where will C&CP leadership be drawn from?**
  - The C&CP Lead for each programme would be recruited on the basis of their expertise and experience, agnostic of particular profession or provider organisation, and would work hand in hand with the Executive ICS programme lead and provide regular progress updates to the C&CPLG.
  - Additional protected time for C&CP Leadership capacity to support whole pathway change from provider collaborations and LCPs
- **ICS paid role/protected time?**
  - For each programme proposed 0.4 WTE ICS role, 0.2 WTE role for each provider collaboration, and 0.2 WTE in each LCP
  - Administrative support through programme management and programmes to be resourced with adequate transformation capability - service redesign, user engagement etc.
- **Other spatial areas where protected time or roles will be required to assure the necessary C&CP System leadership to successfully deliver this function?**
  - All transformation programmes will have varying requirements for C&CP involvement in the implementation of new models of care and innovation - additional resource will need to be identified through appropriate PID/business case development

ILLUSTRATIVE DRAFT