NHS Confederation

Clinical and care professional leadership in integrated care systems

July 2021

Thematic report from engagement events in March 2021 and mini literature review

About

This report summarises the findings of an engagement exercise on the role of clinical and care professionals in integrated care systems.

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

Our Integrated Care Systems Network is an independent national network which supports ICS leaders to exchange ideas, share experiences and challenges, and influence the national agenda.

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Foreword

The NHS Confederation believes that it is vital to retain and enhance clinical and professional leadership as an integral part of collaborative system working, and we know that our members have been working on this important agenda over several years.

As the transition to system working continues and integrated care systems (ICSs) become established as anticipated on a statutory basis, there is a need to ensure that the new organisational culture and structure actively encourages and supports the clinical and care professional voice to thrive, and hence better enable systems to deliver improved outcomes for patients and the wider community. We appreciate that definition of 'clinical and care professional' could lead to protracted debate; the summary definition we offered up at the roundtable events was 'all those in roles who are trained in clinical and care interventions to be delivered to individuals and/or populations'.

We welcomed the opportunity to lead an engagement exercise with our clinical and care professional members and contacts in March 2021 to inform the development of guidance by NHS England and NHS Improvement (NHSEI) on 'what good looks like' in this area. This work was backed up by a mini literature review on clinical and care professional leadership, which included a review of ten case studies across the country.

The engagement work centred on a set of draft principles designed by a multi-professional steering group established by NHSEI. The principles were developed to stimulate thinking on

what clinical and care professional leadership arrangements would be supported by those working in the system in those roles. Two different mechanisms were used to gather opinion: a series of roundtable discussions and an electronic survey.

The response to the roundtables and the survey was impressive, particularly given the short timescales and the considerable pressures currently faced by those on the front line in clinical and care professional roles. Over 1,200 individuals contributed their views and their passion for the critical part they must play in the success of ICSs was both reassuring and energising. We would like to thank everyone who took part for their time and their enthusiasm, and we will look to ensure that we feedback to them as well as to the steering group that commissioned this work.

This report includes separate feedback from both engagement mechanisms; with the mini literature review and case studies contained within Appendix 1. The penultimate section of the report summarises the key themes from both the roundtable events and the survey and aligns this with the literature review. The key themes being as follows:

- Participants like the principles but they are too wordy and jargonistic.

- The principles are generally thought to be inclusive (needs to be tested further with social care) but involvement must be adequately resourced.

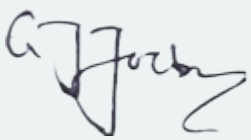
- Must make principles inclusive of experts by experience and be clearer on the need for equality, diversity, and inclusion.

- Professional representation does not have a place in an ICS per se.

- The primacy of place and the need for effective mechanisms for clinical and care professional leadership at this level.

- Mixed views on whether anything should be mandated with passionate views on both sides with the literature review providing support for a proposed resolution.

We would encourage you to read the full report to obtain an insight into the drivers behind these themes and to further your understanding of the different clinical and care professional perspectives, and what lies behind them. We would also like to underline one of our key conclusions which is that there should be an ongoing dialogue with clinical and care professionals about leadership arrangements in an ICS and how they can continue to influence them.



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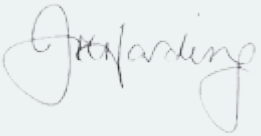

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Background

What the NHS Confederation was commissioned to do and why

In November 2020, NHS England and NHS Improvement (NHSEI) described the practical changes which need to be in place by April 2022 to ensure consistent transition to system working across integrated care systems (ICSs), which are set to become statutory organisations. Clinical and professional leadership was one of the key themes of this work and a commitment was made by NHSEI to produce national guidance that would support system-wide clinical and professional leadership to be embedded in all ICSs.

The system transformation team at NHSEI is leading the production of this guidance and, with a view to informing this work, it commissioned the NHS Confederation to undertake rapid multi-professional clinical engagement throughout March 2021. The engagement work is overseen by an NHSEI steering group, a sub-group of the STP and ICS Clinical and Professional Leaders' Network. Membership includes a range of clinical and care professionals. The NHS Confederation is represented through its senior clinical adviser, Dr Graham Jackson and its director for the Confederation's Integrated Care System Network, Louise Patten.

Scope

We were commissioned to:

- undertake a mini literature review of work already carried out in this area
- identify and collate any examples of 'good' approaches to clinical and professional leadership and involvement in systems, identified during discussions with systems/regions
- carry out engagement with:
  - multi-professional clinical leaders in all 42 systems in England
  - multi-professional clinical leaders in NHSEIs regional teams.
- produce a final thematic report.

Approach to the literature review and review of good approaches

Clinical leadership within ICSs has been the one of the focus areas of the system transformation team at NHSEI. This national collective leadership has enabled sharing of learned experiences in ICS development across the country.

Two key pieces of work have been shared with this team: work undertaken in the Midlands and work undertaken in the South East. These two foci have pulled in case study examples and points of best practice. It is from this starting point that the literature review was conducted by Dr Clare Smith, the national medical director's clinical fellow at NHSEI and paediatric registrar PICU ST7.

Key documents, work programmes and local examples were provided by NHSEI. These were reviewed, key points summarised

and linked with themes from other sources of literature. A full literature search per se was not conducted given that much of this is local knowledge in system domains rather than published academic literature.

The literature review is presented in Appendix 1.

Approach to the engagement

In line with the direction, advice and agreement of the steering group, the engagement:

- took the form of a series of roundtable events and a survey in March 2021
- was structured around seven draft principles for clinical and professional leadership in an ICS; these principles were developed by the steering group and are presented at Appendix 2
- was supplemented by a national engagement process led by System Transformation; output from this engagement process does not fall within the scope of this report.

Who was invited to participate?

Full details of who was invited to participate in a roundtable event and to complete a survey is set out at Appendix 3. As well as direct invitations from the NHS Confederation, sent to its extensive network of members and contacts, each invitee was encouraged to share information about how to register for an event or complete a survey with colleagues within their own organisation or across existing networks.

The invitation to the roundtable event was restricted to those in a clinical or care professional role, using the definition agreed by the steering group.* The survey was opened to all, although the vast majority of those who completed it identified themselves as being a clinician or care professional.

Additionally, everyone who attended a roundtable event was encouraged to share local examples of developing clinical and care professional leadership, which fed into the review of 'good' approaches.

Roundtable events

Initially we planned four roundtable events, which took place on and between 17 March and 25 March. The first two events were open to 75 participants per event, but as it became clear that the events were oversubscribed, and there was confidence that higher numbers could be effectively managed, the final two events were both increased to 85 participants. Two further events were added to the programme which both took place on 31 March. These final events were targeted at nurses in the acute sector and directors of adults and children's services, as it was identified that there was a gap in participation from these two groups.

Participants were sent the draft principles in advance. The key lines of questioning at the event were:

- Are all the principles helpful – would they be useful in informing the design of your ICS?

- Is there anything missing? Are any unnecessary?

* The term 'clinical and care professionals' refers to a wide range of disciplines across health and local government partners. It includes nurses; AHPs; GPs; primary care clinicians; secondary care clinicians, including those without patient-facing roles, such as pathology; public health; social care, including those working in both adult and children's services; healthcare scientists, and pharmacists.

- Do they feel inclusive of all clinicians and care professions? Could this be improved?

- How specific should the principles be about CCP leadership arrangements? Should anything be mandated?

- What national/regional actions are needed to create the right conditions for effective CCP arrangements?

- Are there examples of good practice in your ICS that could help inform guidance on effective CCP leadership?

The events were hosted by clinical leaders from the NHS Confederation. Participants were encouraged to participate in the discussion via a chat facility as well as through the chair. The slides from the event are included at Appendix 4.

Survey

The survey was developed around the framework of the key lines of questioning used at the roundtable events. In designing the survey, we sought to balance a requirement to get responses from a wide range of clinicians with limited time available to complete a long questionnaire, with the need to get a level of detail that was sufficient to inform the development of guidance. In doing this there was an acknowledgement that the survey was part of the engagement process and that the roundtable events were the main mechanism for understanding the breadth and depth of views about what is important to clinical and care professionals about the arrangements for their leadership role in an ICS. The survey is available at Appendix 5.

Summary of findings from roundtable events

Who participated?

In total 384 clinical and care professional leaders registered as a participant. All were asked to identify themselves in the chat function and of the 220 who did so, the largest professional groups represented were GPs (22 per cent); dentists (17 per cent); pharmacists (15 per cent); allied health professionals (14 per cent); nurses (14 per cent) and consultants and/or medical directors (8 per cent).

What did participants think of the principles overall?

Most participants found them to be reasonable, with the overall view being that there was nothing in them that you could argue with. Some said that they liked them and thought they were helpful. However, of the participants that commented, most felt that they were too wordy and jargonistic and as a result inaccessible, with a risk that they would be ineffective and tokenistic. The following comment is illustrative of what we heard.

> “ I think I would agree about language – the principles are well meant but few will work their way through

> to the meaning behind them. I would be concerned that phrases like 'it is the collective responsibility of everybody' risk meaning it is the personal responsibility of nobody. We have to keep in mind that truly inclusive representation of professions and clinical expertise is not the norm and that concerted efforts will be needed to make it so. I would prefer to see simple actionable statements and explicit requirement for ICSs to demonstrate they have been through a process of considering which inputs are needed."

Potentially because the principles were seen as being unwieldy, it was difficult to engage participants in a detailed conversation about the merit and wording of each one. Participants were more animated about what they saw as the changing role of clinical and care professional leadership in an ICS and how the principles would be put into practice: "it's the operationalising and structuring of these into behaviours and practices of the ICSs and systems that is the challenge." An example of this was a concern that the principles of clinical and care professional leadership may be embodied in decision-making about service delivery but absent in other areas, or that some areas of decision-making would be driven by those professionals that have traditionally be involved.

> " Where clinical leadership roles are established there need to be clear expectations about deliverables, lines of accountability and supervision. There can be confusion between clinicians as 'wise experienced professionals' and formal roles in delivering transformation..."

> " I think the principles need to include a definition/ descriptor to differentiate 1. clinical 2. professional and 3. operational leadership. In my experience clinical (multi-professional) leadership and professional leadership are often conflated."

> “I am worried that the language [in principle 3 and 4] only refers to transformational activities and not to the hard end of clinical leadership: accountability and responsibility for continuous improvement in unwarranted clinical variation and health inequalities, responsibility for tools such as clinical engagement, clinical governance, clinical standards across the full range of professional practice.”

> “Voice can still be redundant even if you are round the table if topics are very medically driven.”

Omissions

The resounding response to the question as to whether anything had been left out was that participants were surprised (exasperated even) that there was no mention of patients as experts by experience and, as such, the principles give the impression that co-production is not important. This was mentioned by participants at all six of the roundtables without any prompting beyond the question as to whether anything had been left out.

There was also a view among many participants that equality, diversity and inclusion needed to be a golden thread and that this was not evident. There was one proposal for addressing this which was to split principle 5 as it “mixes up diversity and inclusiveness with championship, enthusiasm and innovation.”

Are the principles inclusive?

There was support for the broadening of the term clinical leadership to clinical and care professional leadership and

participants were generally pleased to see this embedded in the principles.

> “I do like the fact that you are trying to emphasise that this is for all and not just clinicians as this is key and something that has been not been addressed for far too long. We need to change the culture and acceptance of this as there are so many professionals capable but excluded as they are not clinical.”

However, there was a discussion at one of the roundtable events, initiated by a director of adult social care, where it was set out that “by trying to be inclusive about care colleagues we may be becoming exclusive by repeating it all the time.”

There was a strong view, particularly from non-salaried professionals, that an invitation to be involved was not enough and it was important to ensure that people were resourced to enable this.

> “As I was reading the principles, I thought they were great with a nagging thought ‘as long as time is protected to enable input into delivering the clinical leadership required’ - I then saw [principle] 4 and thought this was excellent.”

Should anything be mandated?

There was a strong view from many participants that some mandating would be required. The reasoning behind this varied, from a concern that it would be dominated by the acute trust sector for example, or that primary care networks would be left out, to worries from individual professional groups that felt that their

voice has not been heard in the past and would not be heard in the future unless it was mandated (notably dentists, pharmacists, clinical psychologists and AHPs). “Some level of interdisciplinary leadership will need to be mandated, or else we will be stuck at ‘doctors, nurses and others’.”

However, most participants were against the proposal to mandate anything with a compelling argument made that mandating is both counter-productive to the ethos of an ICS, and ineffective. Counter-productive because “the use of the word mandation is in itself wrong – can’t deliver this in a top-down way”, and ineffective because “it is the behaviours that are important and you can’t mandate behaviour.”

One alternative that was raised independently by at least one participant at each roundtable event, and which received strong support from other participants, was to establish outcomes or to define a standard and then leave it to each ICS to decide how to deliver this.

> “I cannot express strongly enough my vehement objection to even the use of the word mandated... the narrative, the direction of travel appears to be increasingly centralised... which is effectively what mandating does... that is the exact opposite of how to make this a success... if you are going to mandate anything, mandate the outcomes.”

> “... mandate what clinical/professional leadership must achieve, leave the how.”

The discussion about the need or otherwise to mandate aspects of delivering clinical and care professional leadership connected with one of the most frequently raised points across all the roundtable discussions – that of professional representation and

the need to move away from it in an ICS. The connection of these two discussions emerged because mandating was anticipated as being prescriptive about which professional group or organisation should sit on an ICS board and/or its sub-structures.

Professional representation

As set out above, the resounding view of participants was that there was a need to move away from traditional views of clinical and care professional leaders having a seat at the table for the purpose of representing their professional group. Instead, participants articulated that the role is about having the necessary skills and appropriate mechanisms in place to tap into broad clinical and care professional knowledge that can best address the needs of the community. We heard that to be the 'right' clinical or care professional leader, you need an ability to be professionally agnostic, particularly at board level, as the role is not about being from a particular profession or specialty.

> "Whoever sits at the table, I don't mind whether it is a doctor, nurse, pharmacist or anybody that represents me to do my job to help patients get the care they need. The more we talk about whether it's a doctor, is it a nurse, an AHP, the more we start to divide ourselves and miss the point about going into an ICS."

In the context of this being the role, the critical success factors for clinical and care professional leadership discussed by participants were:

1. **Being clear on purpose** – with a focus on a clearly articulated purpose there is then the ability to bring in the right people with the rights skills and knowledge at the right time.

There was a strong view that this should not be confined to describing the profession of the person that was needed, and it linked back to arguments about why mandating specific clinical and care professional representation was not effective.

> "I think we should focus more on 'the why' as many boards can exist and have clinicians and professionals represented but there needs to be a purpose … is it for statutory purposes or engagement or decision making or transforming …"

2. **Having effective mechanisms to tap into broader clinical and care professional knowledge** – to ensure that clinical and care professional leaders can capture the views, knowledge, skills, and experience of clinicians and care professionals across the system. Comments that fell into this category were the most frequently made across all the roundtable sessions.

> "…I think the premise here is there are many tables and there are many seats and… the key thing is making sure that we have those absolute golden threads between those workers on the ground… and those people that have seats at the highest tables whether they are in your place, whether they are in your neighbourhood, whether they are in a bigger ICS…"

3. **The primacy of place** – flowing from the concept of selecting people to be involved and lead based on purpose, and matching this with relevant skills, participants articulated that it was clinical and care professional leaders working alongside communities at place level that really had to be heard within an ICS. There was a strong need voiced for effective mechanisms at place level to deliver this, both within and across organisations in the ICS and within and across professional groups. The need for these effective mechanisms and a move

to distributive leadership was the most frequently made point at every roundtable discussion, with the role of leaders at ICS level seen as being to listen. There was a concern that the primacy of place and principle of subsidiarity did not come out clearly enough in the principles and a worry that this had been lost.

> “ It doesn’t really come out that we need to empower place and communities and that the role of the system is to listen – so if the purpose is population health then hearing from people working at this level is important.”

Summary of findings from the survey

Full detail of the quantitative analysis from the survey is set out in Appendix 6.

Who participated?

- In total 1,251 people responded to the survey, with the largest professional group represented being AHPs (25 per cent) followed by GPs (14 per cent); nurses and midwives (12 per cent); medical consultants (11 per cent); N/A (7 per cent); public health consultants (7 per cent); other (7 per cent); psychologists (6 per cent) pharmacists (5 per cent). The professional groups with the fewest respondents were healthcare scientists (2 per cent); general dental practitioners/dental consultants (2 per cent) and social workers (1 per cent).

- The largest group in the 'other' category were doctors, including trainees and speciality doctors, but this group also included those in public health roles, AHP professionals, dental professionals and psychological professionals. The not applicable category applied to those respondents who stated that they were not in a clinical or care professional role.

- In terms of geographical area, there was a spread across all systems with the largest group being from the Greater Manchester ICS (7 per cent).

What did respondents think of the principles overall?

- For each principle, **over 90 per cent of respondents strongly agreed or agreed with the statement that it was the right one to help their ICS develop clinical and care professional arrangements**. This ranged from 91 per cent for principle 2 and principle 3, to 97 per cent for principle 7.

- While this support is encouraging, it must be set in the context of comments that the **principles lack specificity and are too wordy and jargonistic**. There was a view that the lack of plain English would be particularly antagonistic to those who need to be engaged with them.

- There were some **notable comments about support for population health and a focus on communities, and a concern that the principles did not reflect the critical role of local government and public health expertise**; some did not recognise that public health or other care professionals in local government were included in the term 'clinical and care professional leader.'

- There were comments across the principles about the need to **adequately resource them so that all clinical and care professionals could be involved in a leadership capacity**. This was particularly evident for principle 5 and principle 6.

Key themes by principle

Principle 1: It is the collective responsibility of everybody in a system to create a collaborative and permissive culture in which clinical and care professionals from the NHS, public health and social care work in partnership with non-clinical/managerial colleagues; recognising and using one another's skills and using their expertise and knowledge to improve people's lives and tackle inequalities in outcomes and access.

- 95 per cent of respondents agreed or strongly agreed that this principle was the right one.

- The use of the term non-clinical/managerial colleagues provoked comment for different reasons. Some were concerned that it implied too much power to managers; others that it undermined non-clinicians and was divisive.

- There were comments that the private sector and third sector were not included and several comments about the absence of co-production with patients, carers, the public and communities.

- It was also noted by many respondents that collective responsibility could be interpreted as no one being accountable.

Principle 2: Clinical and care professional leadership, across the NHS, public health and social care, is embedded at every level of the system, recognising existing structures and networks as appropriate; with clear lines of sight and connectivity between the levels, enabling meaningful dialogue and decision-making.

- 91 per cent of respondents agreed or strongly agreed that this principle was the right one.

- There were numerous comments that the phrase 'recognising existing structures' was problematic as what is currently in place may be insufficient or inadequate.

- Some felt that the principle suggested a hierarchical and top-down approach and wanted to emphasise the two-way nature of connectivity and the importance of partnership working at a local level.

Principle 3: Systems have clearly described mechanisms and communications processes in place which ensure full integration of clinicians and care professionals in decision-making, service change and implementation of ICS priorities. Systems will be able to evidence how this is working in practice, at every level of the system, and in all functions such as place, provider collaboratives, system change, and in working with patients and local communities.

- 91 per cent of respondents agreed or strongly agreed that this principle was the right one.
- Concerns about the principle itself tended to fall into two areas:
  - That being communicated with would potentially qualify as having met the principle and yet it could exclude clinical and care professionals from decision-making.
  - That the requirement to evidence could create a burdensome bureaucracy and that it gave the perception of a command-and-control approach.
- There was a plea from many participants for multi-disciplinary involvement.
- Reference to patients and communities was welcomed, although some expressed a view that it came across as an afterthought.

Principle 4: The work of clinicians and care professionals in leadership roles is equally valued. They need a clear understanding of the ICS strategy and priorities and require protected time and resources to undertake transformational activities. They must have access to appropriate data infrastructure, digital enablers and analytical resources, supporting a data-driven approach to decision-making and enabling them to effectively address population health need and the wider determinants of health and health inequalities.

- 93 per cent of respondents agreed or strongly agreed that this principle was the right one.

- This principle generated the most comments, mostly about the importance of the need for access to shared data, although some made the point that it is information rather than data that is required, and that this information should be about outcomes that are important to people in local communities.

- Some respondents felt that the principle excluded public health professionals on the basis that their role was not specified in relation to a function where they have a specific leadership role.

- Some interpreted the principle as implying that setting strategy and decision-making would take place at the top of a hierarchy and the involvement of clinicians and care professionals was in implementing a strategy agreed elsewhere. Respondents emphasised the need to ensure that this was not the case.

Principle 5: Systems must create a diverse and inclusive talent pool, and adopt open, fair and equitable ways of identifying current and future leaders which encourage traditionally under-represented clinical and care profession groups to take on system leadership roles. System leaders should be champions, enthusiasts, and innovators; people who can influence, engage, and pull people together around a single, unifying purpose, based on improving health outcomes and using population health management techniques.

- 95 per cent of respondents agreed or strongly agreed that this principle was the right one.
- The comments overall suggested that many respondents interpreted the focus of the principle differently; some that it was about professional role diversity and others that it was about the protected characteristics of clinical and care professional leaders being representative of the populations they serve.
- There were numerous comments about the need to support the development of leaders from diverse backgrounds.
- There was a concern from some respondents that this would precipitate a 'quota' system which they did not want, whether this be based on professional role or protected characteristics. Conversely, others did want something of this nature in place, although those who supported this system were almost exclusively referring to a target for specific professional roles being represented.
- Some respondents were uneasy about detailing the nature of leadership qualities required within the principle (such as 'innovator').

- There were several respondents who were uncomfortable about specifying 'population health management techniques', either because it came across as a panacea or because it undermined the particular skills of public health in this field.

Principle 6: Systems will have a clearly defined support offer that recognises the different skill set, behaviours and relationships required when working effectively across organisational and professional boundaries; a clear training and development plan for clinical and professional leaders at all levels to enable them to work effectively in system roles, and clear signposting to those local, regional and national support offers which clinical and professional leaders in systems can access.

- 95 per cent of respondents agreed or strongly agreed that this principle was the right one.

- This principle generated the most criticism with respect to lack of clarity.

- Many respondents emphasised the need for this to be available and appropriate to all professions and across all organisations within the system, while recognising a continued need for professional-specific training; some linked it to the need to support greater diversity in leadership roles.

- There were some concerns about the exclusion of non-clinical and care professional leaders, either because respondents felt it was important to encompass everyone or because it could suggest that only clinical and care professional leaders need support to work across boundaries.

Principle 7: Systems should adopt a 'learning system' approach, supporting a culture of continuous learning in which measuring the effectiveness of their clinical and care professional leadership arrangements, and adapting their approach based on what is/is not working well, is considered business as usual.

- 97 per cent of respondents agreed or strongly agreed that this principle was the right one, which was the strongest level of support across all seven principles.
- The learning-system approach was valued, although qualified by many as also needing a no-blame culture.
- There were concerns about measuring effectiveness from the perspective of how the metrics would be determined and that it gave rise to the potential to ignore the things that are harder to measure but often more important, such as culture and outcomes, that are important to communities.

Omissions

- 47 per cent of respondents stated that there are other principles which are key to ensuring the development of effective clinical and care professional arrangements in an ICS.
- Additional principles were proposed in several areas including, but not limited to, co-production with patients and communities (the most frequently mentioned); staff wellbeing; parity of organisations in an ICS, as well as parity of role; transparency; research; quality and safety; and the role of clinical and care professionals in scrutiny and accountability.
- There were also several comments about the need to describe the principles in plain English.

Are the principles inclusive?

- 82 per cent of respondents agreed that the principles were inclusive of a wide range of disciplines across health and local government partners.

- There were, however, concerns that there was nothing in the principles to prevent traditionally represented professions and organisations/sectors continuing to dominate. The importance of a refreshed culture and the impact of existing hierarchies was mentioned in relation to this.

- A few respondents felt that the partnership between the NHS and local government should be clearer; that some partners had been excluded (such as the voluntary/independent sector) and that there was discomfort about singling out clinical and care staff. These points were also made throughout the survey in relation to comments on specific principles.

Making the principles stick

- 82 per cent of respondents agreed that it was important to be prescriptive about how an ICS complies with the principles.

- The rationale for this response from many was that without it there would be an inconsistent approach across the country and systems would revert to prioritising those with existing power. Medics, nursing, acute trusts and GPs being most frequently mentioned as holding this position – although some made a distinction here between commissioning GPs and grassroots GPs.

- Many accepted that it was a difficult balance – one respondent appeared to sum up the concerns of many when they stated that: “The balance between prescription and inflexibility is terrifyingly delicate. And most will not achieve it.”

- Some proposed an overall framework to ensure consistency, but with flexibility, and an ability to deviate if this was evidenced in terms of how it best delivered for patients and communities. Others suggested mandating the principles but allowing flexibility on how to achieve them.

What works well currently in your system?

- Almost half of respondents were able to describe something that was working well in their system and many described how they were beginning to embed the principles or values that were like the draft principles. Some commented on the importance of involving everyone in developing these values.

- The initiatives described covered skill-mix and integration, an open and honest culture and investment in leadership at grassroots level. Governance structures were also mentioned, but there was a recognition from some that they needed further development and could feel bureaucratic.

What are the barriers in your system?

- Almost half of respondents were able to describe barriers to the principles in their system.

- The most common themes were lack of time/insufficient staff; poor communication (with some commenting that this was due to different value across professional groups and organisations); and poor information/IT.

- Others felt that the size of the ICS/organisational changes were a barrier, with staff on the ground feeling disconnected.

What can NHS England and NHS Improvement do to support systems to make the principles a reality?

- More than half of respondents described something that NHSEI could do to support systems make the principles a reality.

- While the need to mandate was frequently mentioned, responses varied in terms of what this referred to. Some were referring to the principles being mandated, whereas others wanted structures to be specified. In line with a discussion point at the roundtable events, several respondents set out that an overall framework should be provided, but with systems left to do the detail of 'the how'.

- There were numerous comments about the need to listen to clinical and care professionals, particularly those at grassroots level.

- There were calls from some respondents to ensure that specific roles were represented at various levels in the ICS, but views were disparate, with some for example calling for more 'provider' GPs on an ICS and others saying that the reliance on GPs should be reduced.

- Many respondents mentioned the need to provide adequate funding, for a range of purposes. This included parity for social care and mental health, enabling frontline staff to engage with the ICS; facilitating cultural change; and supporting the digital infrastructure.

Summary of key themes from the engagement exercise and alignment with the literature review

- **Participants like the principles, but they are too wordy and jargonistic.**

  This was a theme from both the roundtable events and the survey. The literature review suggests that this is important to address because:

  — robust and clear principles could support systems to embed clinical and care professional leadership from the 'get-go'. (Appendix 1, section 4.1).

  — most staff feel disengaged and principles which are wordy and jargonistic risk further alienating staff. (Appendix 1, section 5.3).

  Other learning from the literature review is that principles need to leave "space for systems to retain autonomy in creating systems that reflect the needs of their local population." Having high-level and short statements like the Nolan principles would allow for this. (Appendix 1, section 4.2).

- **The principles are generally thought to be inclusive of clinical and care professional leaders (needs to be tested further with social care) but involvement must be adequately resourced.**

  Most participants at the roundtable event, along with respondents to the survey, welcomed the term clinical and care professional as being inclusive. Because this was not a unanimous view, and because social care was not well represented in the engagement, this should be further tested. As set out in the summary of findings from the survey, there was a concern about the separation of clinical and care professionals from non-clinical colleagues (for different reasons) and a view that the need to specifically mention care professionals was indicative of a culture where care staff are not inherently involved.

  The need to adequately resource clinical and care professional involvement and the link with inclusion featured in the roundtable discussions and in responses to the survey. The importance of this requirement is underlined in the literature review as part of the key and common themes for what good looks like. (Appendix 1, section 4.4.2).

- **Must make principles inclusive of experts by experience and be clearer on the need for equality, diversity and inclusion.**

  Both the roundtable events and the survey featured these themes, with the discussion of communities and experts by experience particularly prominent in the roundtable events and comments about equality, diversity and inclusion featuring frequently in comments made in the survey.

  The centrality of both themes to an effective ICS is outlined in the literature review (Appendix 1, section 5):

  'Leadership should comprise a diverse and deep skill set that is truly representative of the local population...[6] We should

be aiming for a vibrant community of leaders working across boundaries.'[7] (Appendix 1, section 1).

'ICSs need to recognise that they are part of the communities that they serve.'[7] (Appendix 1, section 4.2).

'The citizen should be at the centre of their care, with a focus ensuring equality of access and elimination of a postcode lottery.' [11]

- **Professional representation does not have a place in an integrated care system per se**

The resounding view of participants at the roundtable was that the decision about which professional group /individual should have a seat at the table should depend on purpose. With a focus on a clearly articulated purpose there is then the ability to bring in the right people at the right time. This linked back to arguments about why mandating things was not an effective mechanism. We heard that to be the 'right' clinical or care professional leader you need an ability to be professionally agnostic at board level as the role is not about being from a particular profession or specialty. This was supported by the literature review which identified that there is a need to 'move beyond traditional ideas and expectations and consider what roles are required to deliver rather than appoint professionals based on a job title.'[7] (Appendix 1, section 4.1)

While the above point about being professionally agnostic was made by some respondents to the survey, it was not as prominent. The survey overall featured more comments that could be categorised as lobbying for specific professional groups to be represented in the ICS. Comments of this nature were not completely absent in the roundtable discussions either.

The literature review offers a perspective which supports the theme that emerged in the roundtable discussions but

encompasses the views expressed in the survey in that it presents non-hierarchical and multi-professional leadership as being key principles for good clinical and care professional leadership (Appendix 1, section 4.4.1). It also calls for professions where there is a dearth of literature on their leadership offer to be supported to produce it and highlights the move to ICS as an 'opportunity for a 'shake- up' in leadership positions and systems should monopolise on this opportunity.' (Appendix 1, section 5.1). While the literature review does not suggest that this means guaranteed places for specific roles (quite the opposite), both approaches could offer assurance to professional groups not traditionally represented that the culture of ICSs would be enabling to future opportunities, without the need to secure a named seat at the table.

- **The primacy of place and the need for effective mechanisms for clinical and care professional leadership at this level.**

  Flowing from the concept of selecting people to be involved and lead based on purpose, and matching this with relevant skills, participants articulated that it was clinical and care professional leaders working alongside communities at place level that really had to be heard within an ICS. There was a strong need voiced for effective mechanisms at place level to deliver this, both within and across organisations in the ICS and within and across professional groups. The need for these effective mechanisms and a move to distributive leadership was the most frequently made point at every roundtable discussion, with the role of leaders at ICS level seen as being to listen. There was a concern that the primacy of place and principle of subsidiarity did not come out clearly enough in the principles and a worry that this had been lost.

  This point featured to some extent in the survey, mainly in response to views on principle 2 where there was a concern about the suggestion of a hierarchical and top-down approach and a desire to emphasise the two-way nature of connectivity and the importance of partnership working at a local level.

This need for 'Agreed principles of subsidiarity in place for local, system, regional or national activities'[4] was also identified in the literature review (Appendix 1, section 4.4.2).

- **Mixed views on whether anything should be mandated, with passionate views on both sides.**

  There was a strong view from many participants at the roundtable that some mandating would be required, essentially because of a worry that it would all be about doctors and nurses again or that acute trust organisations would dominate unless it was mandated otherwise. However, most participants were against the proposal to mandate anything, with a compelling argument made that mandating is both counter-productive to the ethos of an ICS, and ineffective. This position was reflected to some extent in the survey, with respondents supportive of things being prescriptive to ensure consistency, but with different views as to what should be mandated. Many comments suggested a prescribed framework or high-level principles with an ability for a local response with respect to how it was delivered.

  As discussed above in relation to views on the principles, the literature review points to the need for systems to retain a level of autonomy (Appendix 1, section 4.2). Furthermore, it is evident from the range of examples of systems demonstrating effective clinical leadership in action (Appendix 1, section 6) that different but successful approaches have been established. Any move to mandating anything other than a framework or high-level principles could put these arrangements at risk.

Conclusions

The rapid engagement exercise we carried out reached over 1,200 clinical and care professionals and demonstrated a high level of interest in this agenda and a passion for ensuring that effective arrangements for clinical and care professional leadership are in place across all ICSs.

The overall purpose of the engagement work and the review of the literature/existing approaches was to identify key themes that would support the production of guidance on establishing clinical and care professional arrangements. These themes are set out in the previous section.

The review of good approaches detailed in section 6 of Appendix 1 indicates that systems have already begun to embed their own successful arrangements for clinical and care professional leadership at all levels.

There was a high degree of consistency between what we heard at the roundtable events and the responses to the survey about the principles, and there was resounding feedback to make the principles clearer, succinct and free from jargon. There was a suggestion at the roundtable event that the principles should take the form of the seven standards for public life, and this would almost certainly resonate with those who responded to the survey.

The strength of the survey was that it provided an opportunity to engage a larger group of individuals and provided specific feedback on each individual principle, which can be used to

support any re-drafting. The inherent shortcomings of the survey were that there was less opportunity to provide context (unless respondents had attended a roundtable as well) and there was no opportunity for people to revise their views after hearing the opinions and ideas of others.

The roundtable events were an opportunity for a discussion, particularly around the key questions which gave rise to polarised views. It was reassuring to observe a consensus emerging in each roundtable about potential resolutions to these differences. Even where a consensus was not reached, participants demonstrated that they understood and respected why others had an alternative view. This points to a need to ensure that there is a continued dialogue with clinical and care professionals about leadership arrangements in an ICS and how they can continue to influence them.

The literature review has affirmed the need to ensure robust clinical and care professional leadership in ICSs and has provided information that can be used to resolve seemingly polarised views expressed in both the survey and the roundtable discussion.

Appendix 1

Mini literature review

Clinical and care professional leadership within integrated care systems (ICSs)

Contents

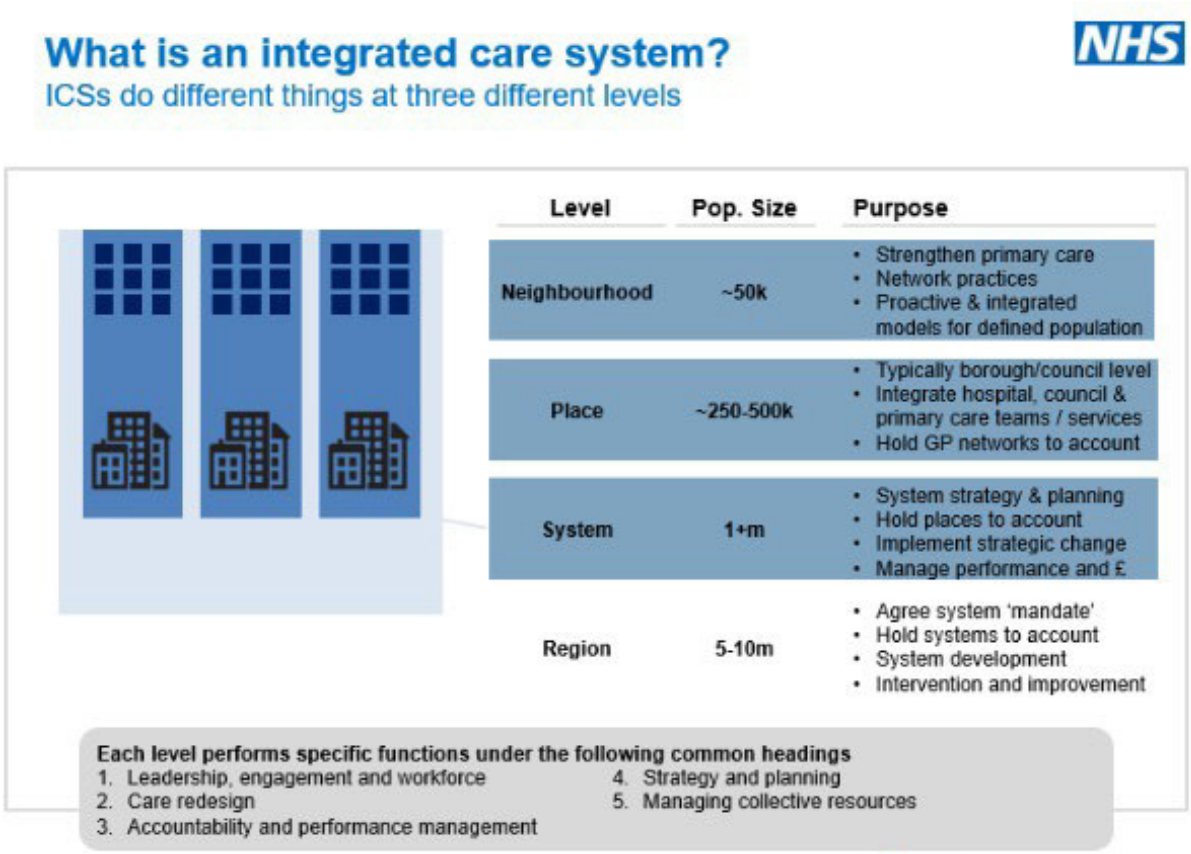
1.0 What is an integrated care system (ICS)?

An integrated care system (ICS) is a partnership that brings together 'providers and commissioners of NHS services across a geographical area with local authorities and other local partners, to plan and integrate care to meet the needs of their population'.[1]

The NHS Long Term Plan set out a vision for ICSs to be established across England by April 2021. It describes ICSs as 'a pragmatic and practical way of delivering the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care'.[2] ICSs are embedded in the NHS Operational Planning and Contracting Guidance 2020/21. Local systems are asked to use their 'system-wide' strategic plans developed in 2019 to deliver the commitments of the Long Term Plan and achieve a 'system by default' approach to delivering care.[3,4] The white paper Integration and Innovation: Working Together to Improve Health and Social Care for All was published in January 2021.[5] It describes the legal framework for integrated health and care services and enables removal of legislative barriers to integration.

Each ICS will be made up of an ICS NHS body and a separate ICS health and care partnership, bringing together the NHS, local government and partners. The ICS NHS body will be responsible for the day-to-day running of the ICS. The ICS health and care partnership will bring together systems to support integration and address the system's health, public health and social care needs.[5]

There are 42 ICSs across England. Development of ICSs has been locally led, with different areas forming their ICS in distinctive ways and at differing rates. System working requires a new mode of 'distributive' leadership, gathered around a new infrastructure of system (1 million), place (300,000-500,000) and neighbourhood (50,000).[6] ICSs need to recognise that they are part of the communities they serve.[7]



2.0 Purpose

This mini literature review describes what is already known about clinical and care professional leadership within ICSs, provides case study examples and identifies where further work is required to enhance knowledge and understanding.

3.0 Clinical and care professional leadership in ICSs – the why?

Clinical and care professional leadership is key to enable the vision for ICSs both nationally and locally to become a reality.[6]

Historically, the hierarchical healthcare landscape has predominately encouraged and enabled doctors and nurses to dominate leadership and decision-making.[6] More recently,

there has been recognition and facilitation of other professionals to have key leadership roles. Given ICSs are integrating health, care and social services, it is vital that there are equal leadership opportunities for all clinical and care professionals. The term 'clinical and care professional leadership' in this document will be used to represent the full breath of professionals who are key stakeholders in an ICS.

Clinical and care professional leadership is fundamental in high functioning teams.[8] Recent in-vivo, real-time learning from COVID-19 has highlighted the positive impact that engaged clinical and care professional leadership can have on identifying and delivering necessary change.[9] When a system or team collaborate on a common purpose, with aligned aims and a shared goal, the outcomes are substantial.[10]

It is paramount that we 'lock in' the beneficial changes that systems have collectively brought about and use the restoration and recovery from COVID-19 to reflect and harness these changes to apply to health outcomes more broadly.[3] Key factors include backing local initiative and flexibility; enhanced local system working; strong clinical leadership; and the rapid scaling of new technology-enabled service delivery.[3] With this will come reduced bureaucracy, increased collaboration and more locally responsive decision-making.[11]

4.0 Clinical and care professional leadership – the how?

4.1 Embed from the get-go

Clinical and care leadership should be embedded into system development as part of the planning. This will optimise conditions for embedding into the system architecture so that it is highly valued, accurate and sustainable.[9]This will turn the tide from clinical

and care professional leadership as an add-on or optional extra to an integral part of the infrastructure. It is the integration that is the enabler rather than the presence per se of clinical and care professional leaders.[7]

How this is executed in governance structures is critical. It requires us to move beyond traditional ideas and expectations and consider what roles are required to deliver rather than appoint professionals based on a job title.[7]

4.2 Key factors to consider

- The citizen should be at the centre of their care, with a focus ensuring equality of access and elimination of a perceived 'postcode lottery'.[11]

- Leadership requirements are changing and system leadership is different to other forms of leadership, such as organisational leadership.[6]

- The challenge for national organisations is providing oversight and a vision of what good looks like, while ensuring principles and recommendations leave space for systems to retain autonomy in creating systems that reflect the needs of their local population.[9] Local ownership will encourage local design so that systems are bespoke.[6]

4.3 Learning from the past

Systems need to learn from previous examples where healthcare has failed to provide high-quality care.[10] The recommendations from inquiries such as the Francis Report, Bristol, Morecombe Bay, among others, should be considered.[12,13,14] And, in particular, the cumulative risk of newly established teams, inexperienced boards, cost-improvement targets and service acquisitions[12] Recurring

themes included a lack of effective clinical leadership and clinical governance.[14] Processes such as support infrastructure and mentorship should be embedded to mitigate risk of transforming to system working.[10]

As we continue working through the COVID-19 pandemic, we have a very tired workforce. This is a potential risk with an evolving system, new roles and new ways of working.[11] We need to recognise that system leadership is a big ask at an individual level and this should not be underestimated given the current workforce exhaustion.

Collectively this will require strong clinical leadership at the whole-system level beyond the constituent organisations.[10] This is best described by the Care Quality Commission's description of well-led. Clinical and care professional leaders are fundamental given 'the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture'.[15]

4.4 The system approach

Systems should use a consistent model for identifying priorities, using the voice of data rather than potentially biased individual opinion.[9] Tasks and teams need to be created around these priorities and include clinical, professional and managerial leaders. This will focus energy, create strategy and ensure the time, tools and authority to deliver proposals that address the issues and task. The Nottingham and Nottinghamshire ICS has developed an effective consistent model for prioritisation.[9]

4.4.1 What does good look like?

There are a number of important pieces of work which identify elements of good clinical system leadership, including work in

the South East of England[25] and the Midlands.[9] They support Don Berwick's work in identifying factors integral to the success of clinical leadership; clear roles and conditions, time, tools, training and support.[16]

Two main principles:

1. It is non-hierarchical.

2. It is multi-professional at all levels and cross-organisation.[9]

4.4.2 Key and common themes include:

- A strategic plan with collective but clear responsibility[3] that is owned by leaders at all levels.[6] This will be underpinned by a shared sense of interest, ownership and belonging.[7]

- A flexible and adapative approach,[6] given the ICS will develop over time as it matures and as the needs of the system develop.[3]

- A single version of the data.[6] A move towards measuring health outcomes built into pathways.[3] Significant investment may be required to establish capability that can generate data to enable successful systems working.[7]

- An operating model built around improvement methodology and practices.[4]

- Quality improvement (QI) capacity and capability – a culture of improvement and a network of improvers capable of innovation and ability to spread.[6]

- Defined governance and reporting in place, including agreed performance indicators and outcomes that contribute to wider system or regional objectives.[4]

- Agreed principles of subsidiarity in place for local, system, regional or national activities.[4] Historically, there has been confusion regarding who is accountable for what service, with variation across the country.[11]

- Leaders with dedicated time, support and clear job descriptions, including outcomes.[6] Time needs to be protected to allow leaders to spend time on problems and opportunities that can only meaningfully be addressed at system level as opposed to in their own organisation or place.[7] Ensuring adequate time requires organisations to release clinicians and care professionals to contribute to system work.[10] Organisations that are under their own pressures are naturally reluctant to release clinicians to contribute to system work, therefore there is a risk of not getting the right leadership expertise or capacity.[7]

- Space for leaders to come together regularly, fostering a culture of collaboration[6] rather than competition.[11]

- Integration with the wider clinical and workforce leadership structures, with engagement with all relevant stakeholders and regular strategic communications.[4,11]

- Strategy to develop interdependence between clinical and managerial/executive leadership. This was a fundamental characteristic of significant positive system- wide reform of stroke and cancer services in London.[7]

- Administrative and executive support for clinical networks.[7]

- Strategy to identify, train and support leaders. Awareness of and access to local, regional and national leadership and training offers.[6]

- Ensuring a culture of learning and psychological safety is important for those contributing to and investing in system leadership.[7]

Discussion with Our Healthier South East London ICS and Kaleidoscope Health and Care revealed a need to be aspirational and to go beyond traditional ideas of a sustainable and capable workforce.[7] They have been inspired by the USA-based accountable care organisations, which are framed around the quadruple aim: care, health, cost and workforce satisfaction, and joy.[17] The Institute for Health Care Improvement (IHI) has similarly studied 'Joy in Work' and demonstrated that healthcare leaders need to understand what factors are diminishing joy in work, nurture their workforce and address the issues that drive burnout and sap joy in work.[18] We should be able to embody the sense of joy and reward which can come from leadership in health and care at system level.

The overall purpose and role of the ICS is different to the current CCG commissioning model[10]. It is important to recognise the need for transition to adopt roles currently undertaken by NHSEI, including accountability of commissioning, quality assurance and provider performance management.

5.0 Clinical and care professional leadership – the who?

5.1 Finding and using experts

All systems will have innovators, experts and respected leaders within the ranks of their multi- disciplinary clinical and care staff.9 They should be identified and their skill set harnessed to ensure the ICS can flourish. Some of these innovators and experts may not currently be in senior leadership positions.[9,10,11] Clinical and care professional leaders are levers for breaking down barriers that can cause a disconnect between and across services that ICSs are intended to bring together, such as primary and secondary care, health and social care and physical and mental health. The lived reality of these barriers will vary between systems, highlighting

the need for local knowledge and ownership. Clinical and care professional leaders need to communicate within and across sectors to encourage working together to contribute to a shared system improvement journey.[9] More integration will remove barriers to patient care and improve the patient journey, demonstrating the benefit of an ICS.[11]

Leadership should comprise a diverse and broad skill set that is truly representative of the local population in order to fully appreciate and understand need as well as deliver integrated care to improve health outcomes specific to the locality.[6] We should be aiming for a vibrant community of leaders working across boundaries.[7]

Clinical leadership has traditionally been medically/nursing dominated because there is a more coherent career structure.[6] The development of ICSs provides an opportunity for a 'shake-up' in leadership positions and systems should capitalise on this opportunity. Interestingly, the literature championing clinical leadership for nurses, pharmacists and allied health professionals is strong. This appetite is important. There is, to our known knowledge, a lack of literature for other professional disciplines. This in itself should be an action for other professions to be supported to communicate their contribution, so their voice is heard and integrated into the leadership table.

5.1.1 Nurse leadership

The document Integrated Care System (ICS):The Role of Executive Nurse Leadership clearly defines the importance of nurse leadership within an ICS.[10] It outlines the role, responsibilities and competencies expected of the executive nurse leader within an ICS.

Particularly notable are:

i) Nursing staff bring their unique perspective, informed by their expertise and experience. This will support decisions made within

the ICS as a whole and will help ensure that a new culture is developed that ensures the voice of the constituent partners is heard and the interests of patients and the community remain at the heart of discussions and decisions.[10]

ii) Nurse leaders ensure the partnership commission and deliver the highest quality services to secure the best possible outcomes for their population and maintains a consistent focus on quality, integration and innovation.[10]

The nurse leader will bring a broader view, from their perspective as an experienced director, to advise and direct on health and care issues within the ICS footprint and particularly the professional contribution of nursing and midwifery.[10]

5.1.2 Pharmacist leadership

The document Leading Integrated Pharmacy and Medicines Optimisation: Guidance for ICSs and STPs on Transformation and Improvement Opportunities to Benefit Patients Through Integrated Pharmacy and Medicines Optimisation clearly defines the importance of pharmacist leadership within an ICS.[3]

The scope of medicines optimisation is widening from the historical emphasis on prescribing and medicines supply to holistic, integrated, person-centred services, including deprescribing and personalised care.[3] The combination of clinical, scientific, operational design, technical and engineering skills that are unique to the pharmacy professional provide the strong foundations for ensuring patients will benefit from the many new innovations in medicines.[3]

Since September 2018, seven regional pilot sites have been working on developing a Pharmacy and Medicines Optimisation Framework within an existing ICS footprint. Evaluation from pilot sites have stated that success has been dependent on a named system-wide lead supported by a collaborative senior leadership

group, the strength of pharmacy and wider system relationships and consequent ability to influence and engage within and across the system. The key factors that influenced the ability for systems to deliver pharmacy and medicines optimisation were the availability of a professional and sustainable workforce, the system background maturity, system challenges, governance structures and the influence of and engagement with the leadership model.[3]

5.1.3 GP leadership

The GP voice has been heard through response to consultation from the document Integrating Care: Next Steps to Building Strong and Effective Integrated Care Systems Across England.[19]

There is widespread concern that the current strong voice of GPs in commissioning will be diluted and members in senior leadership roles will lose their current positions.[9,11] GPs have described a lack of recognition for the vital role to be played by primary care and general practice in ICSs. They feel a threat to the independence of GP practices, with considerable risk to the autonomy of the role and funding of independent practices.[11]

There is further concern that PCNs are being focused on, yet they do not adequately represent GPs or citizen voice. The role of the PCN is being misinterpreted when their primary role is in collaboration on certain projects rather than being accurately representative of the population. GPs feel the PCN clinical director is likely to have a bias towards their GP practice as they will likely only work in one practice.[11]

5.1.4. Allied health professional (AHP) leadership

The document Allied Health Professionals Within Integrated Care Systems clearly defines the importance of allied health professional (AHP) leadership within an ICS. It describes the development of AHP councils that bring together collective strategic leadership to support the ambitions and priorities of the ICS. AHP faculties,

a commitment in the Interim People Plan, have also been created to focus on workforce, specifically supply, retention, careers, education and training.[4]

AHPs commonly work across organisational boundaries, delivering person-centered interventions in environments where they make the most difference to people's lives. Their autonomy and skill sets make them perfectly placed to transform pathways, reducing fragmentation and bringing care closer to home.[4]

Leadership of Allied Health Professionals in Trusts in England: What Exists and What Matters? supports appointment of a chief AHP to strengthen leadership arrangements to harness the AHP workforce's potential for system redesign, implement new care pathways to improve quality and efficiency, and build workforce capacity and capability to realise the benefits.

Where provider chief AHP leadership is in place, the following benefits have been recognised:

- the workforce is more engaged with the improvement and transformation agenda
- the workforce makes a greater contribution to the strategic priorities and objectives as set out by the trust
- there are greater linkages with regional programmes of work, including quality, operational and education/training
- faster growth and adoption of new ways of working
- joined-up approaches to clinical pathway design and development.[4]

5.2 Train, support and network the experts

Once the innovators, experts and respective leaders have been identified, they need to be connected with non-clinical counterparts and supported as system leaders.[9]

Clinical and care professional leaders have traditionally received very little (or no) training in the skills needed to lead, manage or engage effectively, despite there being leadership required at all levels, from ward to board.[6] Often these roles land in the laps of professionals who are considered to be strong clinically and are liked by their peers.

ICSs will need national support beyond national funding. Systems will require access to the support of national leaders, both clinical/care professional and non-clinical, regional and national networking and learning opportunities, as well as nationally developed online platforms for sharing best practice and peer support.6 Clinical and care leaders demonstrate benefit from support through action learning sets.[7] The Topol Review highlights a specific need for healthcare professionals to have exposure and training in digital tools such as robotics, health-related apps and health informatics.[3]

5.3 Hear the voice of the innovators and experts

The voice of the innovators, experts and respected leaders must not be lost among the background noise. This voice needs to be heard throughout the system and appropriately connect in horizontal and vertical networks, informal and formal meetings, through social media and virtual platforms.[9] ICSs need to champion the role of informed, practical and agile clinical leaders, ensuring the clinical voice isn't diluted into an advisory role.[11]

Research carried out by Britain Thinks tells us that only the most senior health and care staff know what an integrated care system is all about, and that the vast majority of staff feel disengaged.[20]

The ambitions of ICSs will not be realised without a fully engaged and involved workforce. Effective engagement requires networks that are demographically representative by postcode, subject matter and profession and communication for two-way exchange.[6]

5.4 Finding the next generation of system leaders

The system must ensure sustainability and succession planning through investing in development processes that support the identification and skilling of future clinical leads. This can be facilitated by a culture that encourages and enables leadership in all settings and levels, as well as developing clinicians willing to take on a formal system 'leaders' role.[9]

There is a need to recruit younger leaders and promote the concept to students throughout undergraduate education. The role of mentoring and buddy systems are useful to consider.[7]

6.0 Examples of system working demonstrating effective clinical leadership in action

There are many examples of system working across England that demonstrates effective clinical leadership in action. This represents a snapshot of examples that were shared with the team writing this report.

6.1 The Wessex model workplace exchange

The Wessex model workplace exchange was designed to allow pairs of clinicians to spend a half day shadowing each other in their respective workplaces.[21] The model aims to build trust, develop understanding of each other's roles and encourage appreciation

and respect. After the exchange, participants are asked to reflect on their learning and offer quality improvement ideas based on their experiences. This approach is also featured in the work in Dorset on 'Walking in their shoes', which enables professionals to build relationships through workplace shadowing.[23]

6.2 Examples from London

Our Healthier South East London's scoping work uncovered a range of approaches outside of their geography and learning from south-west London. Examples that are notable from work in south-west London include incorporating an ethics committee, a series of deliberately resourced and funded condition-specific networks, a clinical leadership group and a clinical senate to connect and amplify the voice of clinical and care professionals in support of system leadership.[7] Within the South East more specifically, Faculty of Medical Leadership and Management has been working with the South East Leadership Academy to support clinicians emerging from the COVID-19 frontline with safe space conversations.[23] This allows leaders to process and share the challenges and strains of leadership in this context, which is reflected in Schwartz rounds which originated from the Point of Care Foundation.[25]

6.3 Case study: A vision for the New Sussex Model

Three domains:

1) Assurance/representation (at place level)

a. Non-executive, hold to account, represent clinicians. Not part of the system themselves. Historically GPs as CCG chairs, can also be practice managers, nurses, secondary care colleagues.

b. Funded from governance.

2) Subject specific (Sussex-wide level)

a. Such as clinical experts. Mostly consultants but also mental health nurses and AHPs. Networks, for example cancer, respiratory, cardiovascular, diabetes. Advisory role.

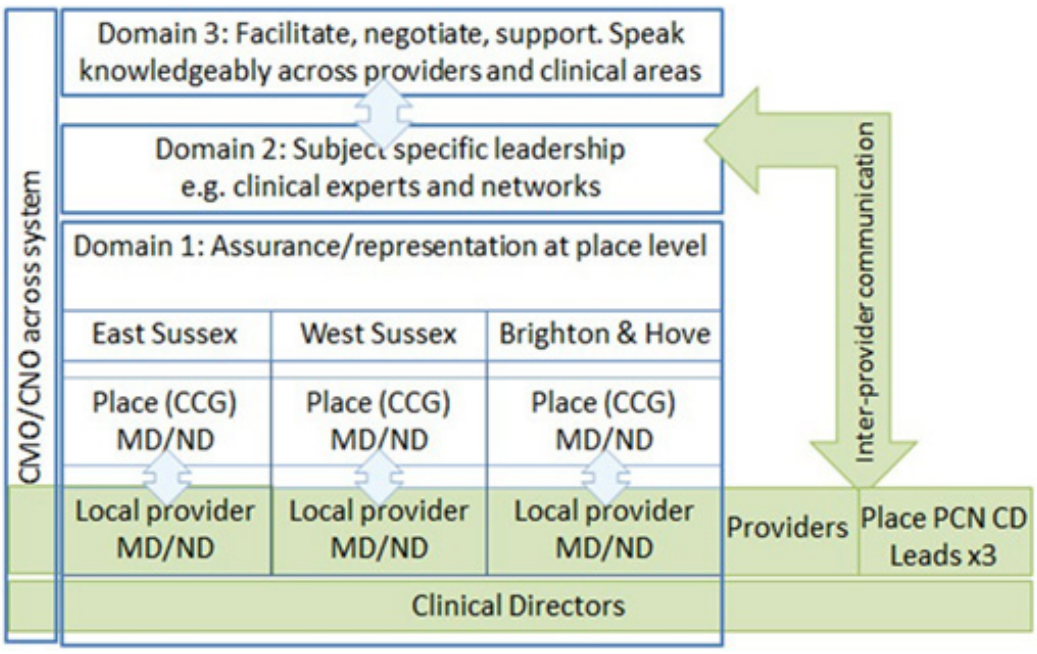
b. Funded from ICS and networks.

3) Facilitation/negotiating/respect (both at place level and Sussex-wide level)

a. Sit over the whole system, arrange deals, sell to secondary care, work with primary care, multidisciplinary. Clinically, chief medical / nursing/pharmacist/AHP officer roles/coach/ referee all in one. Bring generic and political skills. Leadership experience through NHS leadership modules, but need time to do these.

b. Funded from the CCG.

1.6 million population across Sussex – 13 facilitators/negotiators needed. Each would work two days a week in leadership.



6.4 Case study: Frimley Collaborative

Frimley ICS partnership board

System leaders across various disciplines. Commissioners, local authority, lay, PCN leads, medical directors, chief nurses. Sets strategy/agenda/vision/tone/gives permission. Delivery at subcommittees at place level:

- Clinical reference group. Senior medical directors. Set clinical strategy – GPs and clinical pathways.
- Reducing clinical variation workstream. Primary and secondary care.
- Health and wellbeing alliance.

The Frimley Academy – education programme created to bring aspiring leaders together, working across multiple professions to unlock potential in local communities.

Aims/core features:

1) Develop culture that allows for improved patient and community health and care outcomes. Feel valued.

2) Leadership interventions.

3) Clear path to sustainable improvement.

Frimley local patient perspectives

Five-year strategy developed with local residents. Hundreds of residents went through 'inspiration stations' to choose the following topics to focus on in their area:

- Starting well
- Focus on health and wellbeing
- Community deal

- Focus on our people
- Culture leadership (academy)
- Value for money

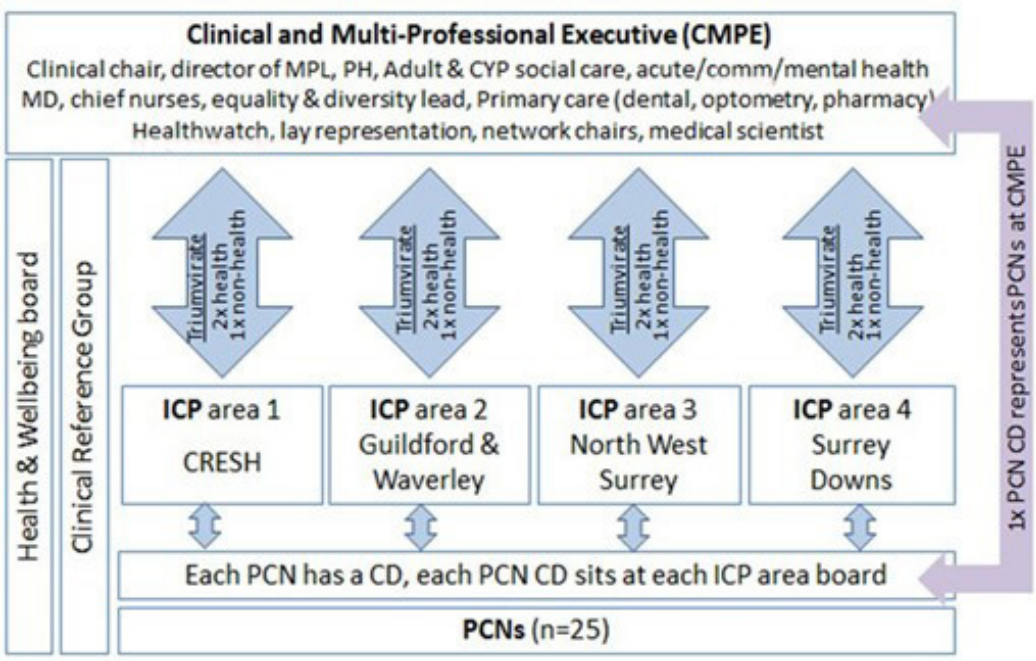
6.5 Case study: Somerset Listening and Responding in Care Homes (LARCH) project

County care home team established to good effect.

- Wanted treatment escalation plans.
- Led to confidence and competence in care homes, reduced admissions by 28 per cent.
- Work included medication reviews, de-prescribing, oral hydration training.
- Collective leadership, shared decision making and co-creating, collaborating and communicating.
- Included occupational therapists, paramedics.
- During COVID-19 everyone was recruited, connected to 200+ care homes.
- Accountable to one person, but collective leadership with trust and shared vision.
- Resource for system to support problem-solving in care homes.

6.6 Case study: Surrey Heartlands ICS

Within Surrey Heartlands ICS there are 25 PCNs. Each PCN has a clinical director (CD) that sits at each ICP area board. There are four ICP areas within the ICS. Each ICP has a triumvirate representation at the clinical and multi-professional executive (CMPE). The triumvirate is composed of two health and one non-health representative. One PCN CD also sits at the CMPE. The health and wellbeing board and the clinical reference group sit vertically across the ICS. The CPME has overall governance and accountability, although various functions and roles are devolved to place level, allowing time-appropriate decision-making that relates to the local population. The CMPE is a diverse multi-professional group with broad representation across the system.

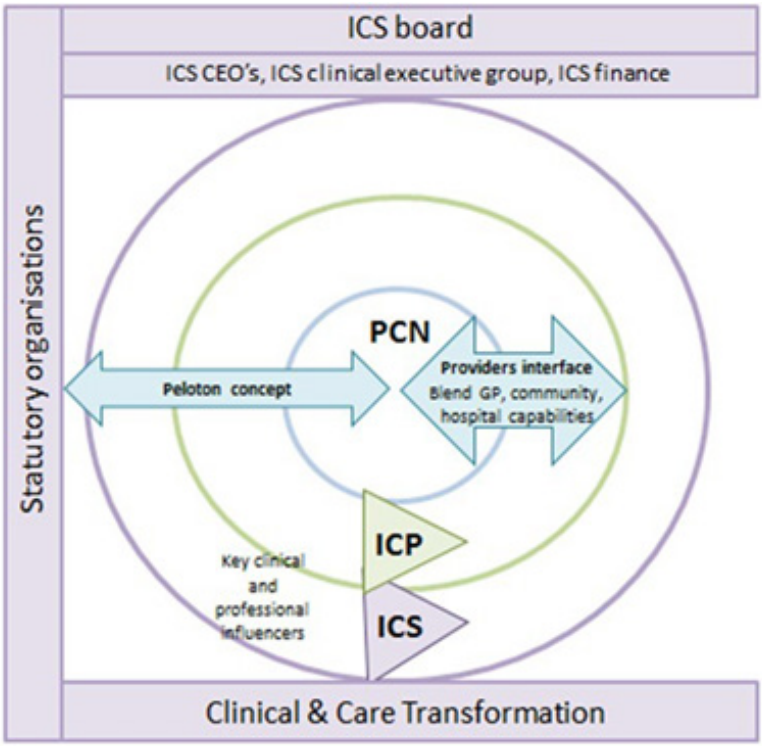


6.7 Case study: Nottingham and Nottinghamshire ICS

The Nottingham and Nottinghamshire ICS is built around an ICS board that has a system prioritisation model which provides the overall ambition for a collaborative structured approach to how planning and prioritisation is managed. The ICS board is composed of a number of clinical leadership groups, including the clinical executive group (responsible for determining priorities and ensuring optimal clinical population value from the available resources), the ICS chief executives and the finance group. The interface between providers and commissioners is a blend of GP, community and hospital capabilities. There are a number of key clinical and professional influencers at every level within the ICS.

The ICS refers to the concept of 'Peloton'. In a cycling road race, a peloton is the main group of leading riders and teams travelling as an integrated unit, whose very complex, cooperative and competitive interactions produce enormous mutual energy savings. Although the interactions between individual cyclists are in principle very simple, with each rider making slight adjustments in response to their adjacent riders, the collective behaviours of the peloton

is very complex. Peloton is central to the ICS's emergence as a truly integrated healthcare delivery system and its future as a pre-eminent accountable care system. Peloton is dedicated to support the ICS health and care providers: primary care, general practice, community services, allied healthcare professionals, specialist clinicians and hospitals, covering the entire care continuum, all of which have agreed to work together and accept collective responsibility to improve the quality of care delivered to patients within the resources allocated. Peloton will work with and for the network of clinicians and support colleagues who provide care to more than 1,100,000 individuals in Nottingham and Nottinghamshire ICS.



6.8 South Yorkshire and Bassetlaw ICS

South Yorkshire and Bassetlaw (SYB) ICS serves a population of 1.5 million, in five local places (Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield). The system includes 72,000 members of staff, 208 GP practices, 36 neighbourhoods, six acute hospital and community trusts, six local authorities, five clinical commissioning groups and four care/ mental health trusts.

SYB ICS identified that they had a higher than national suicide rate among men aged 30-50 years. They used system working and organisational integration to identify local need, quantify the problem, allocate resource (£555,000 allocated to mental health services in May 2018 in order to help fight against suicide) and identify key stakeholders required to deliver and coordinate services. They have established key approaches, including training staff, improved communication between organisations, a large-scale campaign on emotional wellbeing, real- time surveillance, bereavement support, work alongside the media and a retrospective coroner's audit.

This really is everyone's business and why partnerships with the voluntary and community sector, football clubs, prisons, workplaces and increasing community capacity is important to reach out to those who are potentially having mental health difficulties. No one should have no one; reducing loneliness and isolation and reducing the stigma around mental health difficulties should be everyone's responsibility as part of their own wellbeing and that of others.

The main aim of suicide prevention work is to reduce the number of suicides in South Yorkshire and Bassetlaw by 10 per cent.

6.9 Greater Manchester Health and Social Care Partnership

Manchester is a HM Government devolution area and it has chronologically led the way in the journey of ICSs. This undoubtedly lends itself to opportunities to learn about structure and form but also more broadly into other aspects of integrating care. A lot of the learning from Manchester has been echoed in other case studies provided. In addition, Manchester offers a different example in a system approach to supporting an acute trust following a CQC report that highlighted need for improvement. Traditionally, external expertise and support for an organisation would be instigated to

deliver improvements in care. Instead, collective system action drawing on local resource enabled joint commissioner and regulator expertise to address challenges. A system approach will help identify and address challenges outside the organisation that are key influencers, as well as provide a coordinated approach. This points to a future in which provider failure may be seen as a responsibility of the system rather than the responsibility of an organisation.

6.10 Leicester, Leicestershire and Rutland (LLR) ICS

Leicester, Leicestershire and Rutland (LLR) ICS is focusing on developing a culture of clinical leadership with emphasis on clinical leadership with management support. It has identified four pillars of clinical leadership, demonstrated in this organogram:

To support this vision, the current COVID-19 pandemic has provided additional challenges and unique opportunities for clinical leadership to lead system response and transformation. The clinical community identified ways of working that will drive all parts of future clinical leadership culture. The result is ten system expectations developed by the clinical leadership group and has been supported by all partner organisations. This buy-in from all stakeholders is essential for engagement and delivery of system working.

10 System Expectations

1. Safety First
2. Equitable Care for All
3. Involve our Patients and the Public
4. Have a virtual by default approach
5. Arrange care in local settings
6. Provide excellent care
7. Enhanced care in the community
8. Have an enabling culture
9. Drive technology, innovation and sustainability
10. Work as one system with a system workforce

LLR ICS is still finding its way to develop robust governance around infiltrating clinical leadership throughout the system and is currently liaising at neighbourhood and place level to facilitate this. The ICS is actively listening and engaging to ensure sustainable clinical leadership is integrated throughout.

7.0 Conclusion

There is a lot of information at local level demonstrating excellent clinical and care professional leadership. This document reviews available and gathered information. It is important to release and invite further ICS leaders and voice to present and contribute their learning, ideas, concerns and expectations. This will enable continuous peer learning and identifying effective methods of clinical and care professional system leadership. The engagement work carried out by the NHS Confederation will help considerably in filling in these gaps.

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Appendix 2

Design principles: clinical and care professional leadership* in integrated care systems (ICSs)

Context

The following draft principles are intended to provide a framework for integrated care systems (ICSs) when thinking about arrangements for clinical and care professional leadership. Many systems will already be well advanced in their thinking in this area; others will be operating well in some areas, but with varying levels of maturity in others. The purpose of the principles is to support ICSs in defining their operating model for clinical and care professional leadership; and identifying where they need to make progress.

The principles are being developed by clinicians and care professionals in partnership with NHS England and NHS Improvement (NHSEI). We are engaging extensively with a wide range of clinical and care professional colleagues in systems and with NHSEI regional and national colleagues as we progress this work.

Once finalised, they will be underpinned by guidance, to be published in quarter one 2021/22, which will set out the detail beneath each principle, drawing on the extensive experience and good practice already in evidence across many of the more advanced ICSs.

*The term 'clinical and care professionals' refers to a wide range of disciplines across health and local government partners. It includes nurses; AHPs; GPs; primary care clinicians; secondary care clinicians, including those without patient-facing roles, such as pathology; public health; social care, including those working in both adult and children's services; healthcare scientists; and pharmacists.

ICSs will be encouraged to use the principles and guidance to 'self-assess' their progress, sighting the NHS ICS board on identified gaps and further development needs. There will be support on offer to those systems that require it.

This list is not exhaustive, and we will test the terminology during engagement.

The principles

The system environment – What cultural conditions need to be in place in order to harness and 'unlock' the power of clinical and care professional leadership in a system?

1. It is the collective responsibility of everybody in a system to create a collaborative and permissive culture in which clinical and care professionals from the NHS, public health and social care, work in partnership with non-clinical/managerial colleagues; recognising and utilising one another's skills and using their expertise and knowledge to improve people's lives and tackle inequalities in outcomes and access.

2. Clinical and care professional leadership, across the NHS, public health, and social care, is embedded at every level of the system, recognising existing structures and networks as appropriate; with clear lines of sight and connectivity between the levels, enabling meaningful dialogue and decision-making.

Functions and infrastructure – What should be in place at each level of the system? What are the functions required at each level and how are clinicians and care professionals involved in decision-making as well as/ service redesign and transformation?

3. Systems have clearly described mechanisms and communications processes in place which ensure full integration of clinicians and care professionals in decision-making, service change and implementation of ICS priorities.

Systems will be able to evidence how this is working in practice; at every level of the system; and in all functions e.g. place; provider collaboratives; system change, and in working with patients and local communities.

4. The work of clinicians and care professionals in leadership roles is equally valued. They need a clear understanding of the ICS strategy and priorities and require protected time and resources to undertake transformational activities. They must have access to appropriate data infrastructure, digital enablers and analytical resources, supporting a data-driven approach to decision-making and enabling them to effectively address population health need and the wider determinants of health and health inequalities.

Training, development and succession planning – How are clinical and care profession leaders developed and supported to carry out their roles and how is the talent pipeline managed?

5. Systems must create a diverse and inclusive talent pool, and adopt open, fair and equitable ways of identifying current and future leaders which encourage traditionally under-represented clinical and care profession groups to take on system leadership roles. System leaders should be champions, enthusiasts, and innovators; people who can influence, engage, and pull people together around a single, unifying purpose, based on improving health outcomes and using population health management techniques.

6. Systems will have a clearly defined support offer that recognises the different skill set, behaviours and relationships required when working effectively across organisational and professional boundaries; a clear training and development plan for clinical and professional leaders at all levels to enable them to work effectively in system roles, and clear signposting to those local, regional, and national support offers which clinical and professional leaders in systems can access.

7. Systems should adopt a ‘learning system’ approach, supporting a culture of continuous learning, in which measuring the effectiveness of their clinical and care professional leadership arrangements, and adapting their approach based on what is/is not working well, is considered business as usual.

Appendix 3

Clinical and care professional leadership: NHS Confederation engagement plan

Stakeholder group/ network	Network description	Key clinical/care professional group to target	Approach to engagement	Date	Comments
NHSCC Clinical Leaders Forum	GP chair and executive nurse leads in CCGs	272 GPs and CCG nurses at executive level	Invite to roundtable events	11/3/2021	
			Invite to share invitation to roundtable with their own networks	11/3/2021	
			Invite to participate in survey	19/3/2021	
			Invite to share links to survey with their own networks	19/3/2021	
NHSCC Nurse Forum	CCG nurses (not included in Clinical Leaders Forum above)	Additional 129 CCG nurses	Invite to roundtable events	11/3/2021	
			Invite to share invitation to roundtable with their own networks	11/3/2021	
			Invite to participate in survey	19/3/2021	
			Invite to share links to survey with their own networks	19/3/2021	

NHS Confederation's Mental Health Network	Includes mental health medical directors in the NHS and independent sector; mental health directors of nursing and mental health aspiring directors of nursing	Circa 80 medical directors; 60 directors of nursing and 15 aspiring directors of nursing in mental health NHS trusts and foundation trusts, and the independent sector	Invite to roundtable events	12/3/2021
			Invite to share invitation to roundtable with their own networks	12/3/2021
			Invite to participate in survey	19/3/2021
			Invite to share link to survey with their own networks	19/3/2021
NHSEI system stakeholder list	Includes clinical leads	13 senior leaders in ICSs	Invite to roundtable events	11/3/2021
			Invite to share invitation to roundtable with their own networks	11/3/2021
			Invite to participate in survey	19/3/2021
			Invite to share link to survey with their own networks	19/3/2021
Individual expressions of interest	Individuals who have expressed an interest in being involved in this work, either directly to the NHS Confederation or via NHSEI	Ten senior clinical/ care professional leaders in dentistry, optometry, pharmacy, public health, scientific officers, general practice and primary care nursing	Invite to roundtable events	11/3/2021
			Invite to share invitation to roundtable with their own networks	11/3/2021
			Invite to participate in survey	19/3/2021
			Invite to share link to survey with their own networks	19/3/2021

Individual contacts of the NHS Confederation	These are senior clinical and care professional leaders across the NHS working at system level or in professional bodies who have participated in producing NHS Confederation policy documents	52 senior clinical/care professional leaders including chief officer of Association of Directors of Adult Social Services; chief executive of Queen's Nursing Institute and chief executive of the Royal Pharmaceutical Society	Invite to roundtable events	Majority on 11/3/2021 with 23 delayed until 16/3/2021	
			Invite to share invitation to roundtable with their own networks	Majority on 11/3/2021 with 23 delayed until 16/3/2021	
			Invite to participate in survey	19/3/2021	
			Invite to share link to survey with their own networks	19/3/2021	
Regional clinical leads	Individuals connected to work that the NHS Confederation is also involved with via Dr Graham Jackson	Seven RMDs, Two commissioning RMDs Chief Allied Health Professions Officer, Chief Scientific Officer, Chief Dental Officer With professional links across all trusts in England	Invite to roundtable events	11/3/2021	List used to invite to roundtable omitted regional chief nurses and regional directors of public health. Nursing gap addressed through chief nurse in the Midlands who shared with her peers on 16 March with request to share with networks
			Invite to share invitation to roundtable with their own networks	11/3/2021	
			Invite to participate in survey	19/3/2021	Mailing list was amended to include all regional chief nurses. Medical directors and chief nurses asked to share with their public health director colleagues as these emails were not available via NHSE.
			Invite to share link to survey with their own networks	19/3/2021	
			Invite to target acute nursing to attend additional roundtable on 31 March	25/3/2021	Regional chief nurses asked to send invitation to additional roundtable to acute nurses in their network.

PCN Network	NHS Confederation network	C 1,200 members working in primary care networks and GP federations. Largely clinical directors but includes nurse leaders, pharmacists and chief executives of federations	Invite to participate in survey	25/03/2021
			Invited to attend roundtable events on 31 March (events set up specifically to target PCN clinicians and care professionals in social care)	25/03/2021
Community Network	NHS Confederation network	Approximately 150 members in community trusts	Invite to participate in survey	23/03/2021
Care professionals in social care	NHS Confederation contact at ADASS and the president of Association of Directors of Children's Services	Chief executive of ADASS	Targeted personal email asking for survey link to be sent to ADASS/ADCS colleagues	19/3/2021
	ADASS website trawl for email of directors of social services on regional groups/ Follow-up email to ADASS chief executive	Chief executive of ADASS plus two regional leads of ADASS and nine directors of social services with email contacts available on the ADASS website	Invite to complete the survey and to attend the targeted roundtable event on 31 March	24/3/2021
Roundtable attendees	Those registered on a roundtable event and not on existing contact lists	265 individuals	Invited to complete the survey	19/3/2021

Appendix 4

Integrated Care Systems Network
NHS Confederation

Clinical and care professional leadership in integrated care systems – for discussion at roundtable events

(Graham Jackson, Louise Patten, Jo Harding. March 2021.)

Background

- Clinical and professional leadership is fundamental to the success of ICSs.

- NHS England and NHS Improvement commissioned the NHS Confederation to undertake rapid multi-professional clinical engagement to inform this work.

- Outputs from this engagement will be used to inform the development of draft guidance.

Scope

- Mini literature review.
- Rapid but wide engagement:
    - All ICS/STP systems.
    - NHSEI regions.
    - Confed-established networks.
    - Balance of multi-professional input.
    - Local authority involvement with public health and social care.

- Seek opinion on a set of design principles.
- Use roundtables and survey methods.
- Produce a consensus report that can be used to inform guidance to sit alongside the bill.

Cohort definition

Must encompass all those in roles who are trained in clinical and care interventions to be delivered to individuals and/or populations.

In short...

"Clinical and care professionals"

(Please introduce yourselves in the chat.)

The system environment: What cultural conditions need to be in place in order to harness and 'unlock' the power of clinical and care professional leadership in a system?

1. It is the collective responsibility of everybody in a system to create a collaborative and permissive culture in which clinical and care professionals from the NHS, public health and social care work in partnership with non-clinical/managerial colleagues; recognising and using one another's skills and using their expertise and knowledge to improve people's lives and tackle inequalities in outcomes and access.

2. Clinical and care professional leadership, across the NHS, public health, and social care, is embedded at every level of the system, recognising existing structures and networks as appropriate; with clear lines of sight and connectivity between the levels, enabling meaningful dialogue and decision-making.

Functions and infrastructure: What should be in place at each level of the system? What are the functions required at each level and how are clinicians and care professionals involved in decision-making as well as service redesign and transformation?

3. Systems have clearly described mechanisms and communications processes in place which ensure full integration of clinicians and care professionals in decision-

making, service change and implementation of ICS priorities. Systems will be able to evidence how this is working in practice; at every level of the system; and in all functions such as place, provider collaboratives, system change, and in working with patients and local communities.

4. The work of clinicians and care professionals in leadership roles is equally valued. They need a clear understanding of the ICS strategy and priorities and require protected time and resources to undertake transformational activities. They must have access to appropriate data infrastructure, digital enablers and analytical resources, supporting a data-driven approach to decision-making and enabling them to effectively address population health need and the wider determinants of health and health inequalities.

Training, development and succession planning: How are clinical and care profession leaders developed and supported to carry out their roles and how is the talent pipeline managed?

5. Systems must create a diverse and inclusive talent pool and adopt open, fair and equitable ways of identifying current and future leaders which encourage traditionally under-represented clinical and care profession groups to take on system leadership roles. System leaders should be champions, enthusiasts and innovators; people who can influence, engage, and pull people together around a single, unifying purpose, based on improving health outcomes and using population health management techniques.

6. Systems will have a clearly defined support offer that recognises the different skill set, behaviours and relationships required when working effectively across organisational and professional boundaries; a clear training and development plan for clinical and professional leaders at all levels to enable them to work effectively in system roles; and clear signposting to those local, regional and national support offers which clinical and professional leaders in systems can access.

7. Systems should adopt a 'learning system' approach, supporting a culture of continuous learning in which measuring the effectiveness of their clinical and care professional leadership arrangements, and adapting their approach based on what is/is not working well, is considered business as usual.

Principles (in summary)

System environment

- Collaborative and permissive culture.
- Embedded at every level.

Function and infrastructure

- Decision-making/communications/implementation of strategy.
- Resources data/time/support.

Training, development and succession planning

- Development of diverse talent pool/professional equity.
- Development support local/regional/national.
- Learning environment.

Questions

1. Are all the principles helpful? Would they be useful in informing the design of your ICS?

2. Is there anything missing? Are any unnecessary?

3. Do they feel inclusive of all clinicians and care professions? Could this be improved?

4. How specific should the principles be about CCP leadership arrangements? Should anything be mandated?

5. What national/regional actions are needed to create the right conditions for effective CCP arrangements?

If there are examples of good practice in your ICS that could help inform guidance on effective CCP leadership, please feedback to: dawn.smith@nhsconfed.org

Survey being distributed, feel free to share.

Appendix 5

NHS Confederation

Draft design principles: clinical and care professional leadership in integrated care systems (ICSs)

Thank you for agreeing to complete this survey – by participating you will be directly contributing to the development of national guidance which will drive the way in which clinical and care professional leadership will be established in an ICS. The results will feed into an independent report that the NHS Confederation has been commissioned to produce by NHS England and NHS Improvement. To help us ensure that your views are included, please complete this survey before close of play on 31 March.

The purpose of the principles is to provide a framework for all integrated care systems (ICSs) to design effective arrangements for clinical and care professional leadership. With this purpose in mind, please tell us whether you think the principles are the right ones.

Principle 1: It is the collective responsibility of everybody in a system to create a collaborative and permissive culture in which clinical and care professionals from the NHS, public health and social care work in partnership with non-clinical/managerial colleagues; recognising and utsing one another's skills and using their expertise and knowledge to improve people's lives and tackle inequalities in outcomes and access.

Q1 This principle is the right one to support an ICS to develop effective clinical and care professional arrangements? **Strongly agree/Agree/Disagree/ Strongly disagree**

Q1a If you wish, please make a comment to explain your response.

Principle 2: Clinical and care professional leadership, across the NHS, public health and social care, is embedded at every level of the system, recognising existing structures and networks as appropriate; with clear lines of sight and connectivity between the levels, enabling meaningful dialogue and decision-making.

Q2 This principle is the right one to support an ICS to develop effective clinical and care professional arrangements? **Strongly agree/Agree/Disagree/ Strongly disagree**

Q2a If you wish, please make a comment below to explain your response.

Principle 3: Systems have clearly described mechanisms and communications processes in place which ensure full integration of clinicians and care professionals in decision-making, service change and implementation of ICS priorities. Systems will be able to evidence how this is working in practice; at every level of the system; and in all functions such as place; provider collaboratives; system change; and in working with patients and local communities.

Q3 This principle is the right one to support an ICS to develop effective clinical and care professional arrangements? **Strongly agree/Agree/Disagree/ Strongly disagree**

Q3a If you wish, please make a comment below to explain your response.

Principle 4: The work of clinicians and care professionals in leadership roles is equally valued. They need a clear understanding of the ICS strategy and priorities and require protected time and resources to undertake transformational activities. They must have access to appropriate data infrastructure, digital enablers and analytical resources, supporting a data-driven approach

to decision-making and enabling them to effectively address population health need and the wider determinants of health and health inequalities.

Q4 This principle is the right one to support an ICS to develop effective clinical and care professional arrangements? **Strongly agree/Agree/Disagree/ Strongly disagree**

Q4a If you wish, please make a comment below to explain your response.

Principle 5: Systems must create a diverse and inclusive talent pool and adopt open, fair and equitable ways of identifying current and future leaders which encourage traditionally under-represented clinical and care profession groups to take on system leadership roles. System leaders should be champions, enthusiasts and innovators; people who can influence, engage, and pull people together around a single, unifying purpose, based on improving health outcomes and using population health management techniques.

Q5 This principle is the right one to support an ICS to develop effective clinical and care professional arrangements? **Strongly agree/Agree/Disagree/ Strongly disagree**

Q5a If you wish, please make a comment to explain your response.

Principle 6: Systems will have a clearly defined support offer that recognises the different skill set, behaviours and relationships required when working effectively across organisational and professional boundaries; a clear training and development plan for clinical and professional leaders at all levels to enable them to work effectively in system roles, and clear signposting to those local, regional, and national support offers which clinical and professional leaders in systems can access.

Q6 This principle is the right one to support an ICS to develop effective clinical and care professional arrangements? **Strongly agree/Agree/Disagree/ Strongly disagree**

Q6a If you wish, please make a comment to explain your response.

Principle 7: Systems should adopt a 'learning system' approach, supporting a culture of continuous learning, in which measuring the effectiveness of their clinical and care professional leadership arrangements, and adapting their approach based on what is/is not working well, is considered business as usual.

Q7 This principle is the right one to support an ICS to develop effective clinical and care professional arrangements? **Strongly agree/ Agree/ Disagree/ Strongly Disagree**

Q7a If you wish, please make a comment to explain your response.

Q8 Are there any additional principles that you believe are key to ensuring the development of effective clinical and care professional arrangements in an ICS? **Yes/No**

Q8a If yes, briefly describe them below.

Q9 The draft principles above will ensure that clinical and care professional arrangements in an ICS are inclusive of a wide range of disciplines across health and local government partners. **Strongly agree/ Agree/Disagree/Strongly disagree**

Q9a If you disagree – please tell us what you believe needs to be in place to ensure that the clinical and care professional arrangements in an ICS are inclusive of a wide range of disciplines across health and local government partners.

Q10 In your view, how important is it to be prescriptive about how an ICS complies with each of the principles to 'make them stick' e.g., by mandating structures and mechanisms for clinical and care professional arrangements. **Very important/ Important/Unimportant/Not at all important**

Q10a If you wish, please make a comment to explain your response.

Q11 Does your system embody any of the principles already? If so, please tell us what works well.

Q12 If you do not recognise some of the principle in your current system arrangements, please tell us what you think the barriers might be?

Q13 What can NHS England and NHS Improvement do to support you in making the principles a reality in your system?

Q14 Are you a clinical or care professional (whether in a patient-facing role or not)?
Yes, I work in a clinical/care professional role
No, I am a non-clinician/manager

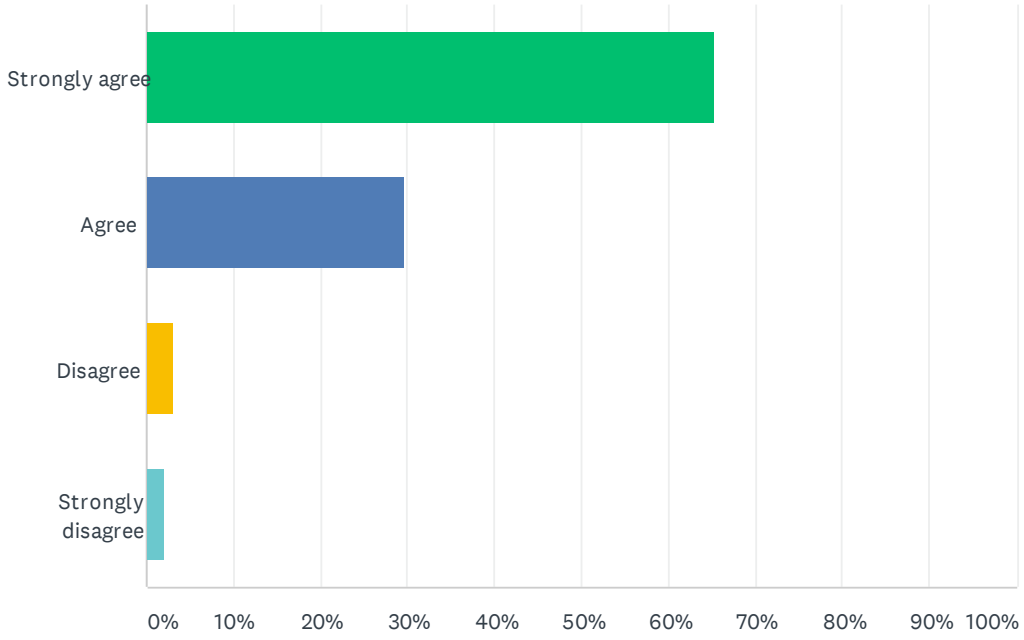
Q14a If yes, which clinical/care professional group do you work in?

Q15 Which geographical ICS area do you work in (if applicable)

Appendix 6:
Draft design principles - clinical and care professional leadership in integrated care systems (ICSs)

Q1 This principle is the right one to support an ICS to develop effective clinical and care professional arrangements?

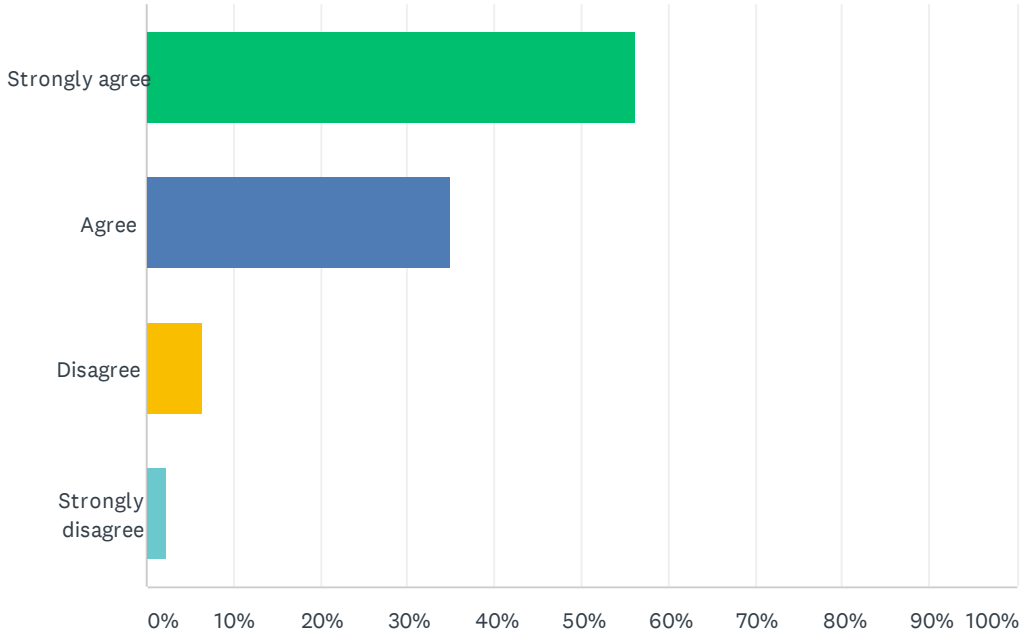
Answered: 1,251 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	65.23%	816
Agree	29.66%	371
Disagree	3.04%	38
Strongly disagree	2.08%	26
TOTAL		1,251

Q2 This principle is the right one to support an ICS to develop effective clinical and care professional arrangements?

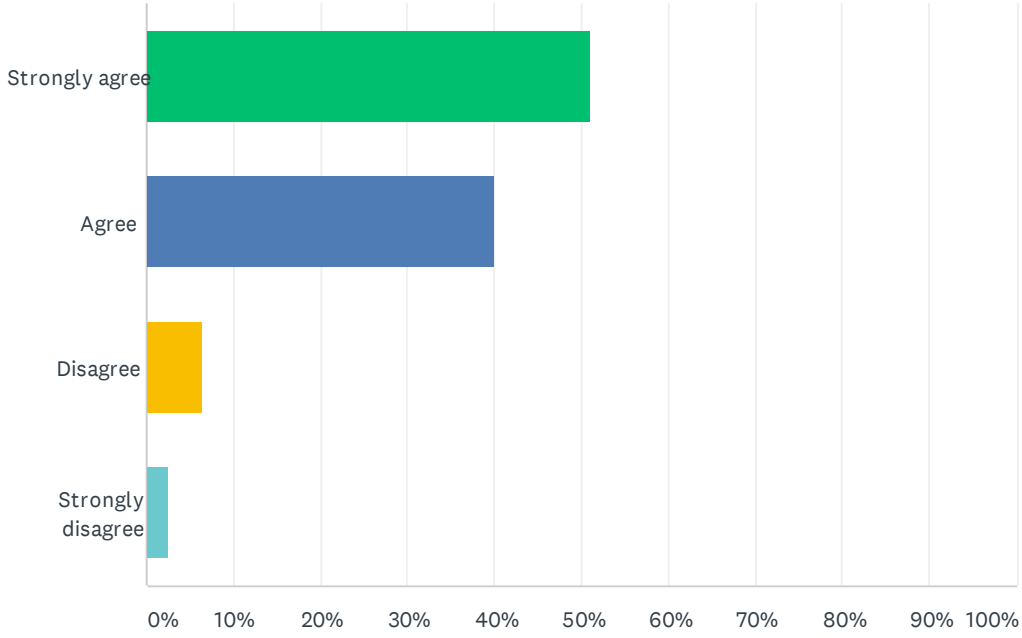
Answered: 1,251 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	56.20%	703
Agree	34.93%	437
Disagree	6.47%	81
Strongly disagree	2.40%	30
TOTAL		1,251

Q3 This principle is the right one to support an ICS to develop effective clinical and care professional arrangements

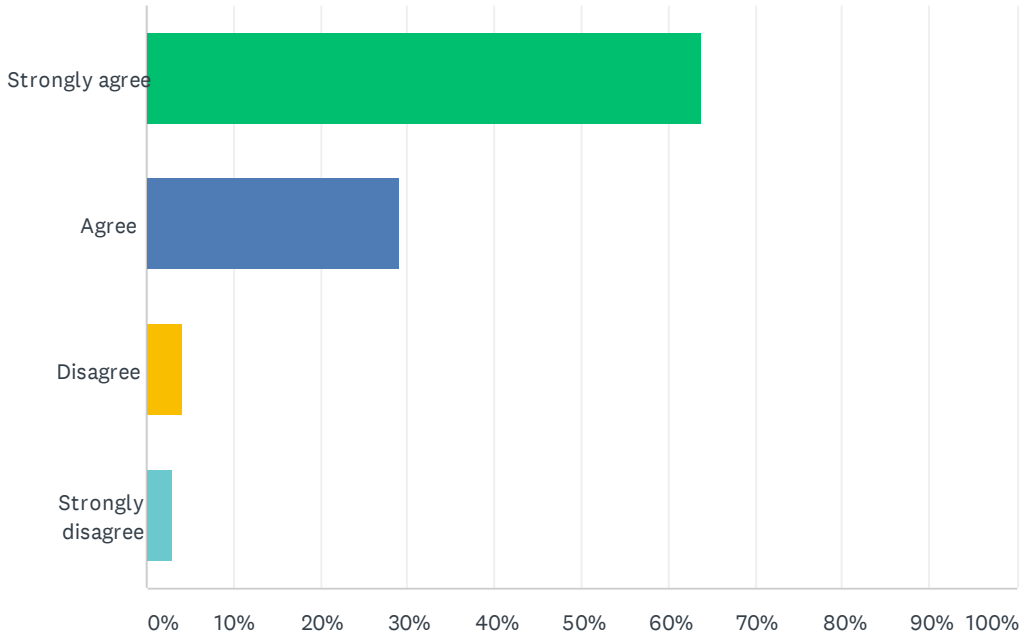
Answered: 1,251 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	51.08%	639
Agree	39.97%	500
Disagree	6.47%	81
Strongly disagree	2.48%	31
TOTAL		1,251

Q4 This principle is the right one to support an ICS to develop effective clinical and care professional arrangements?

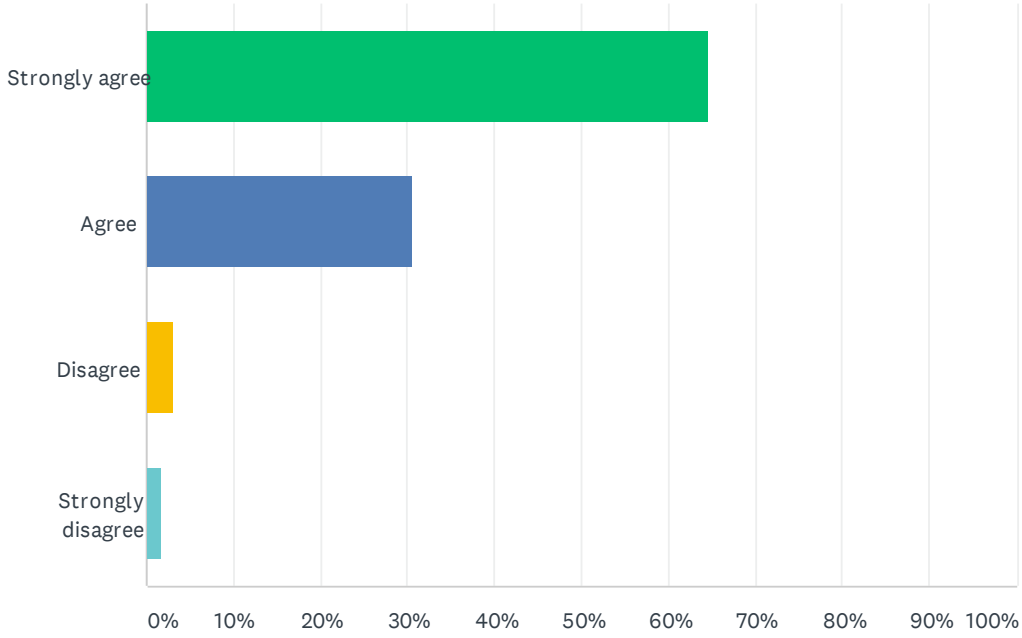
Answered: 1,251 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	63.71%	797
Agree	29.18%	365
Disagree	4.16%	52
Strongly disagree	2.96%	37
TOTAL		1,251

Q5 This principle is the right one to support an ICS to develop effective clinical and care professional arrangements?

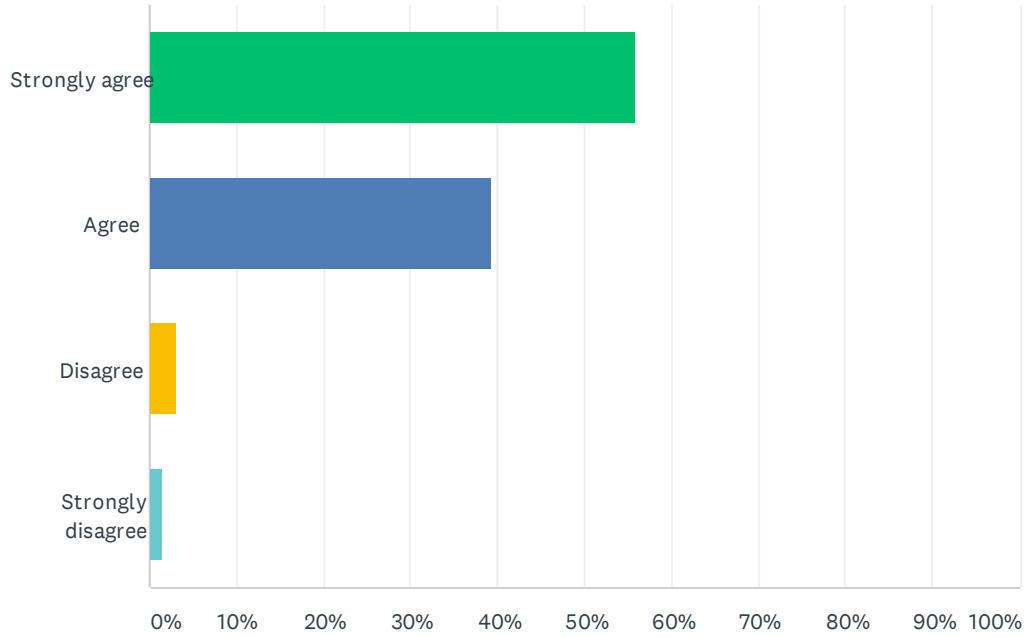
Answered: 1,251 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	64.75%	810
Agree	30.54%	382
Disagree	3.12%	39
Strongly disagree	1.60%	20
TOTAL		1,251

Q6 This principle is the right one to support an ICS to develop effective clinical and care professional arrangements?

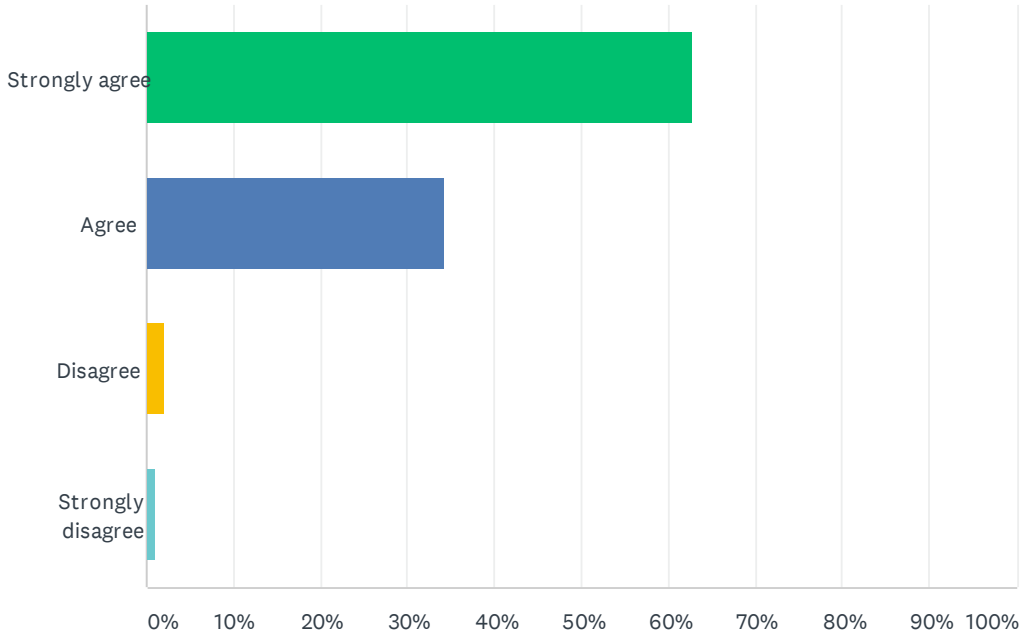
Answered: 1,251 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	55.96%	700
Agree	39.41%	493
Disagree	3.12%	39
Strongly disagree	1.52%	19
TOTAL		1,251

Q7 This principle is the right one to support an ICS to develop effective clinical and care professional arrangements?

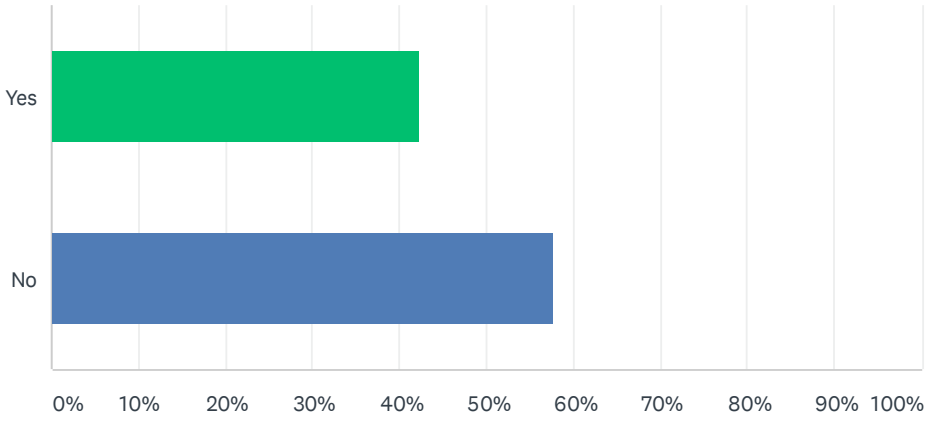
Answered: 1,251 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	62.75%	785
Agree	34.21%	428
Disagree	2.00%	25
Strongly disagree	1.04%	13
TOTAL		1,251

Q8 Are there any additional principles that you believe are key to ensuring the development of effective clinical and care professional arrangements in an ICS?

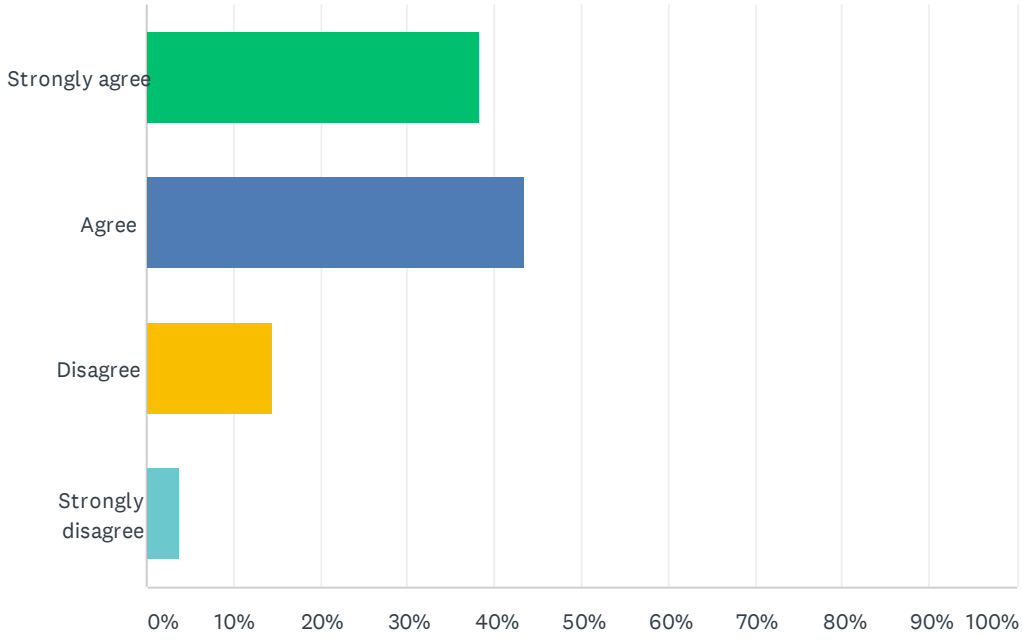
Answered: 1,251 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	42.29%	529
No	57.71%	722
TOTAL		1,251

Q9 The draft principles above will ensure that clinical and care professional arrangements in an ICS are inclusive of a wide range of disciplines across health and local government partners

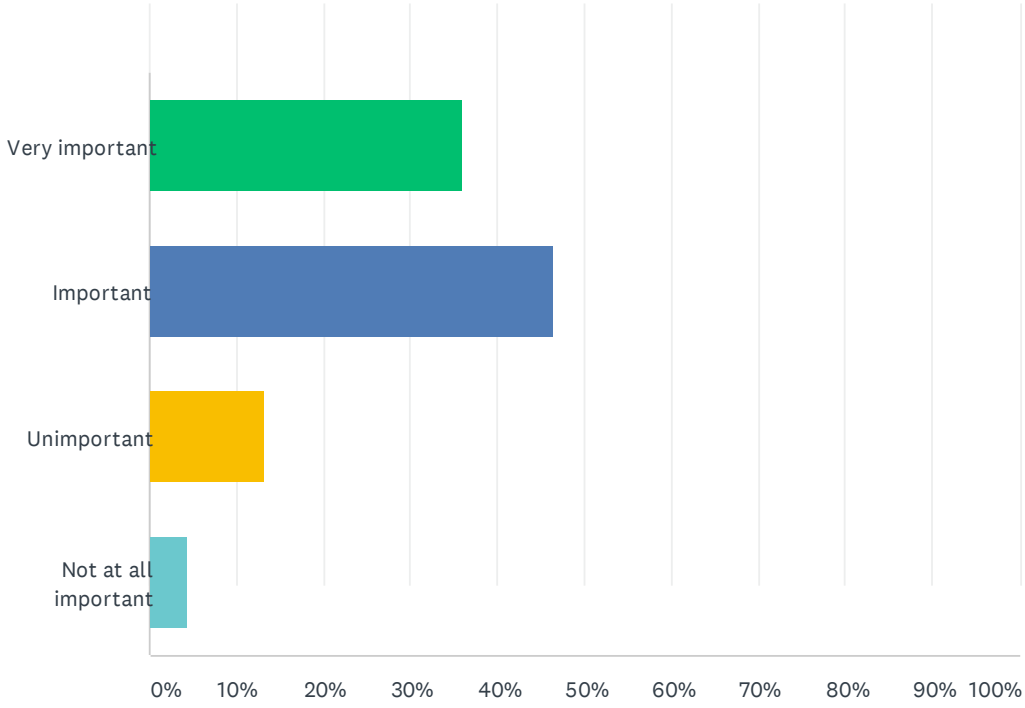
Answered: 1,251 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	38.21%	478
Agree	43.57%	545
Disagree	14.47%	181
Strongly disagree	3.76%	47
TOTAL		1,251

Q10 In your view, how important is it to be prescriptive about how an ICS complies with each of the principles to 'make them stick' e.g., by mandating structures and mechanisms for clinical and care professional arrangements.

Answered: 1,251 Skipped: 0



ANSWER CHOICES	RESPONSES	
Very important	35.97%	450
Important	46.52%	582
Unimportant	13.19%	165
Not at all important	4.32%	54
TOTAL		1,251

Q11 Does your system embody any of the principles already? If so, please tell us what works well

Answered: 531 Skipped: 720

Q12 If you do not recognise some of the principle in your current system arrangements, please tell us what you think the barriers might be?

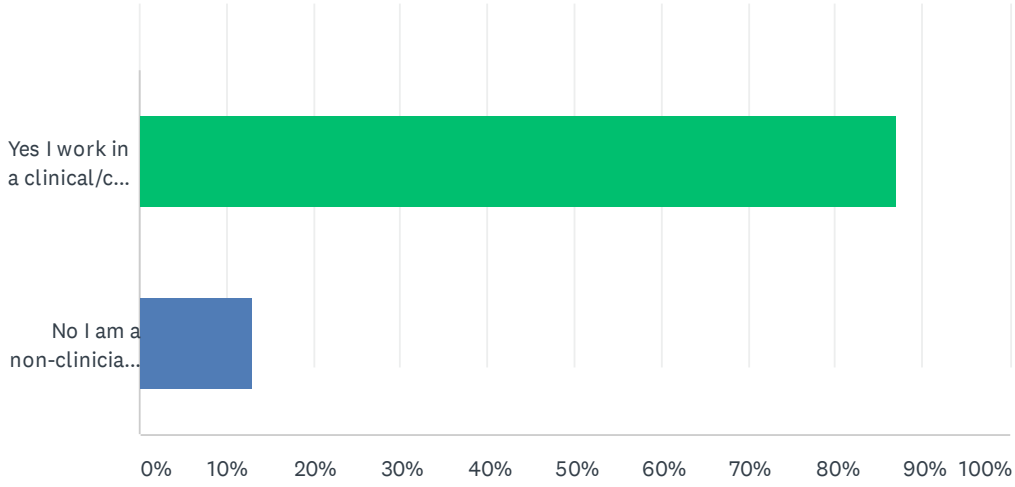
Answered: 533 Skipped: 718

Q13 What can NHS England and NHS Improvement do to support you in making the principles a reality in your system?

Answered: 630 Skipped: 621

Q14 Are you a clinical or care professional (whether in a patient-facing role or not)?

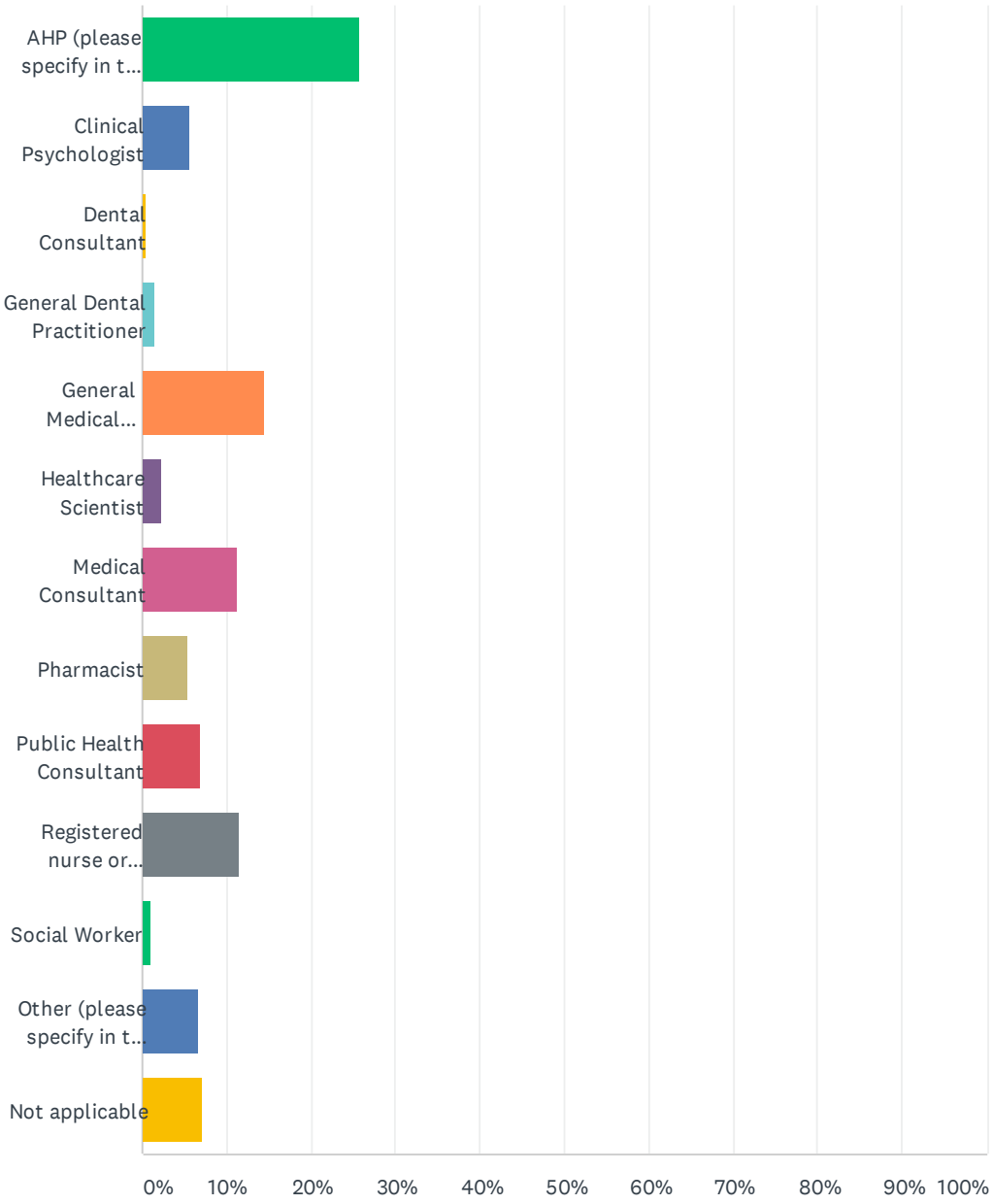
Answered: 1,251 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes I work in a clinical/care professional role	86.97%	1,088
No I am a non-clinician/manager	13.03%	163
TOTAL		1,251

Q15 If yes, which clinical/care professional group do you work in (please select not applicable if the answer is no)

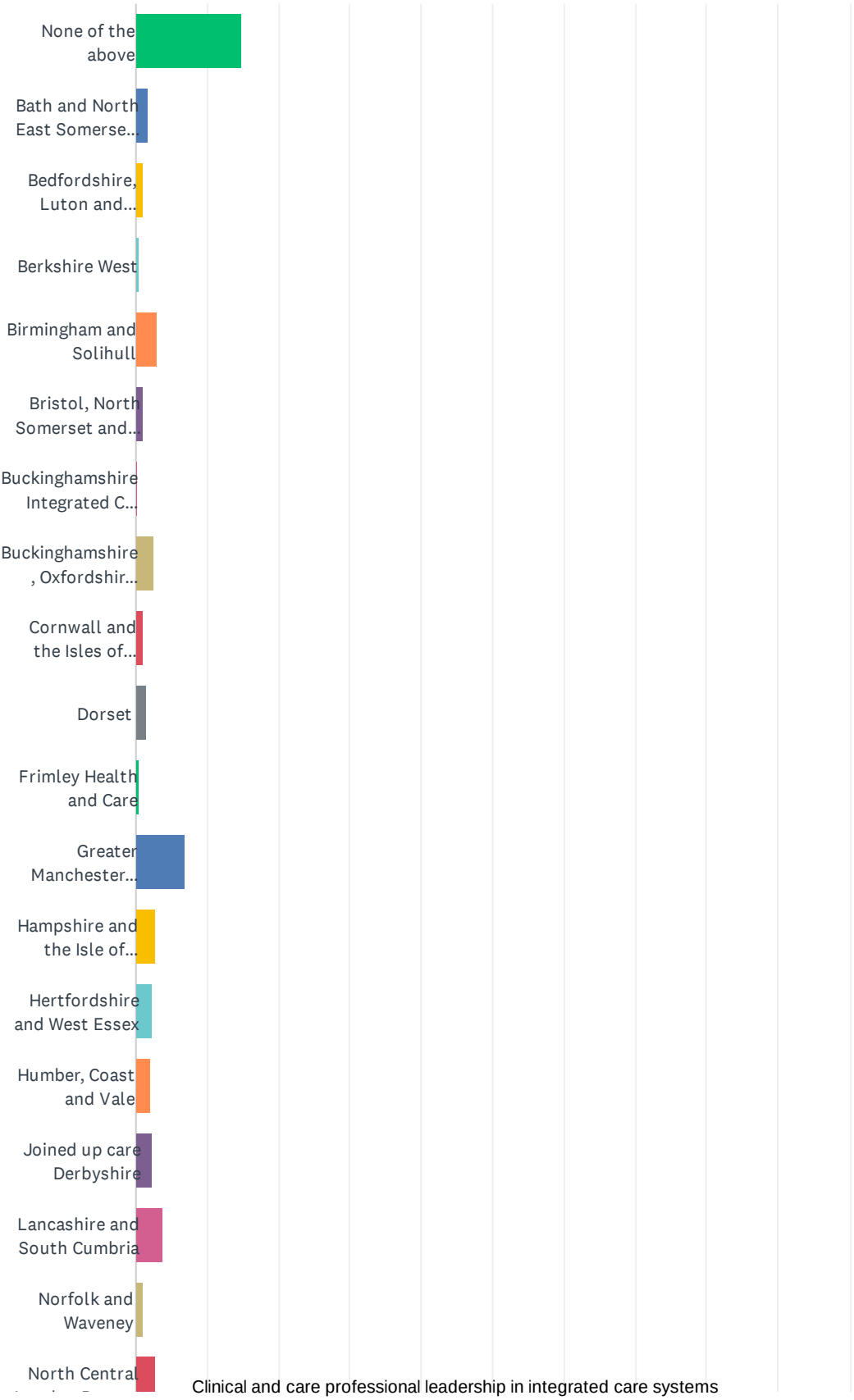
Answered: 1,251 Skipped: 0



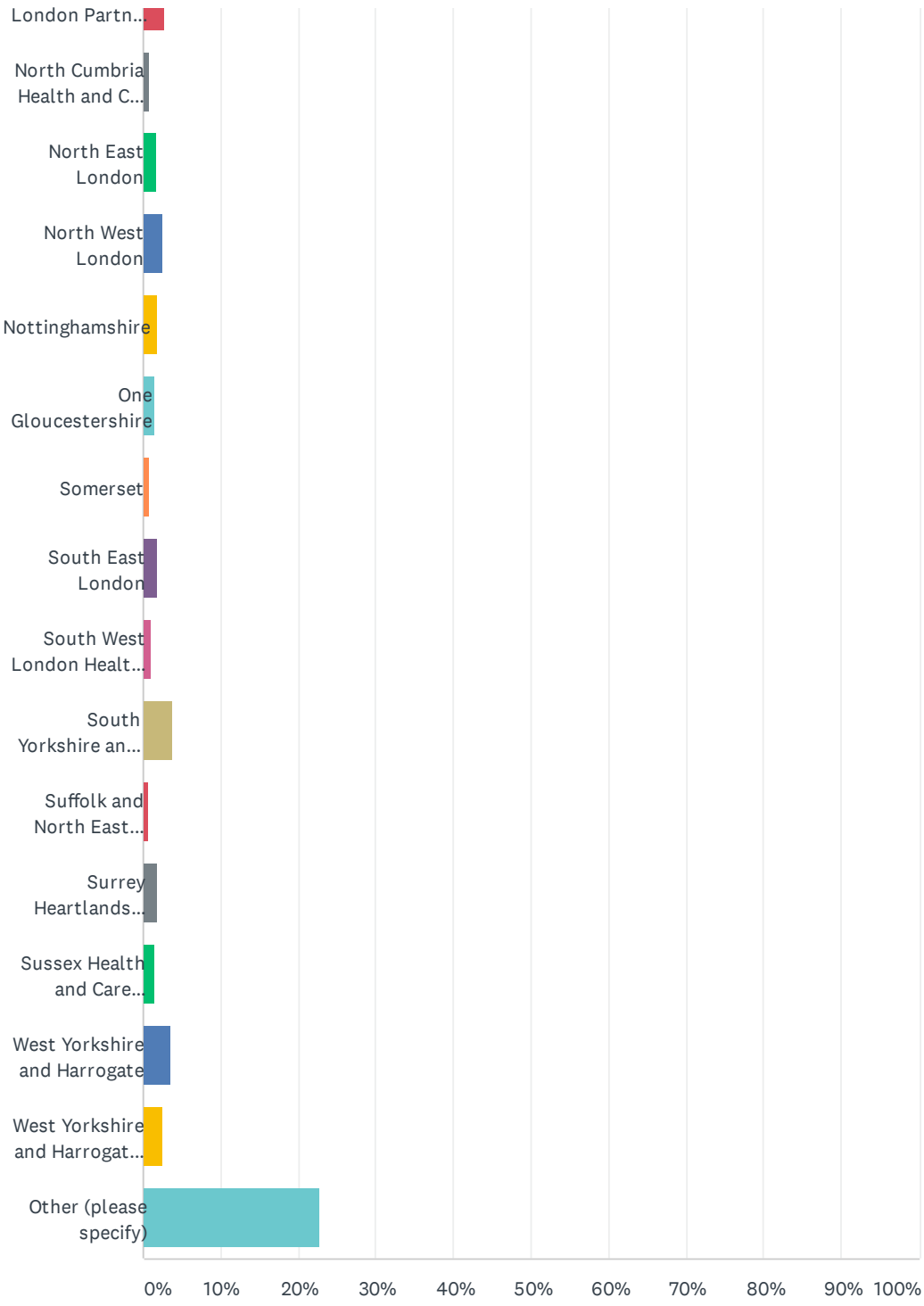
ANSWER CHOICES	RESPONSES	
AHP (please specify in the comments below)	25.74%	322
Clinical Psychologist	5.68%	71
Dental Consultant	0.48%	6
General Dental Practitioner	1.44%	18
General Medical Practictioner	14.39%	180
Healthcare Scientist	2.24%	28
Medical Consultant	11.27%	141
Pharmacist	5.36%	67
Public Health Consultant	6.87%	86
Registered nurse or midwife (please specify in the comments below)	11.59%	145
Social Worker	1.12%	14
Other (please specify in the comments below)	6.63%	83
Not applicable	7.19%	90
TOTAL		1,251

Q16 Which geographical ICS area do you work in (if applicable)

Answered: 1,251 Skipped: 0



Clinical and care professional leadership in integrated care systems


London Partn...
North Cumbria Health and C...
North East London
North West London
Nottinghamshire
One Gloucestershire
Somerset
South East London
South West London Healt...
South Yorkshire an...
Suffolk and North East...
Surrey Heartlands...
Sussex Health and Care...
West Yorkshire and Harrogate
West Yorkshire and Harrogat...
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

ANSWER CHOICES	RESPONSES	
None of the above	14.79%	185
Bath and North East Somerset, Swindon and Wiltshire	1.68%	21
Bedfordshire, Luton and Milton Keynes	1.04%	13
Berkshire West	0.32%	4
Birmingham and Solihull	2.88%	36
Bristol, North Somerset and South Gloucestershire	1.04%	13
Buckinghamshire Integrated Care System	0.16%	2
Buckinghamshire, Oxfordshire and Berkshire West	2.56%	32
Cornwall and the Isles of Scilly	0.96%	12
Dorset	1.52%	19
Frimley Health and Care	0.40%	5
Greater Manchester Health and Social Care Partnership	6.95%	87
Hampshire and the Isle of Wight	2.80%	35
Hertfordshire and West Essex	2.32%	29
Humber, Coast and Vale	2.00%	25
Joined up care Derbyshire	2.24%	28
Lancashire and South Cumbria	3.68%	46
Norfolk and Waveney	1.04%	13
North Central London Partners in health and care	2.64%	33
North Cumbria Health and Care System	0.88%	11
North East London	1.60%	20
North West London	2.56%	32
Nottinghamshire	1.92%	24
One Gloucestershire	1.52%	19
Somerset	0.88%	11
South East London	1.92%	24
South West London Health and Care Partnership	1.12%	14
South Yorkshire and Bassetlaw Integrated Care System	3.76%	47
Suffolk and North East Essex	0.56%	7
Surrey Heartlands Health and Care Partnership	1.84%	23
Sussex Health and Care Partnership	1.52%	19
West Yorkshire and Harrogate	3.60%	45

West Yorkshire and Harrogate Health and Care Partnership	2.48%	31
Other (please specify)	22.86%	286
TOTAL		1,251

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