APPENDIX B

Joined Up Care Derbyshire
Clinical and Professional Leadership Group (CPLG)
Final DRAFT Terms of Reference
December 2022

1.0 Purpose

The Joined Up Care Derbyshire vision is to improve Life Expectancy and Healthy Life Expectancy for the people and communities we serve AND reduce the Health Inequalities driving these differences. CPLG as an agnostic group provides clinical and professional leadership which directs the system in achieving this vision and in doing so, drives achievement of the Quadruple Aim of improving patient outcomes, improving patients' experience of care, improving staff experience of delivering care and to reduce the per capita cost of health care.

The primary purpose of the CPLG is to act as the clinical and professional conscience for the Integrated Care System (ICS) by providing collective direction, impetus and guidance, which enables the system to achieve its strategic priorities to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money, and
- Help the NHS support broader social and economic development

CPLG has a central role in the development of wider system Clinical and Professional Leadership and have agreed a Clinical and Professional Leadership Model (see Appendix 1) which underpins everything the group does. The vision for CPLG is:

"The Clinical and Professional Leadership Group (CPLG) will facilitate, strengthen and build clinical & professional leadership within the Joined Up Care Derbyshire ICS so that the best outcomes for the population are achieved collectively. We will do this by ensuring clinicians and professionals are ***involved, informed,*** *have the* ***ability*** *and* ***opportunity*** *to* ***influence*** *and* ***lead*** *decision making at all levels; supported by trusted and connected leadership".*

CPLG will:

- Be driven by the interests of the people and communities we serve; ensuring health and care services are designed to meet the needs and wants of the people who use them, not the organisations who provide them
- Be recognised, utilised and connected in decision making at all levels as the strategic Clinical and Professional Leadership Group in the ICS by influencing and informing the ICS strategic agenda through high quality advice and shared learning
- Ensure system developments and transformation are aligned to consistent frameworks/principles; seeking to ensure shared learning, innovation and following evidence-based practice
- Act as the clinical and professional conscience for the system; making recommendations to the ICB, ICP and other strategic groups
- Provide an 'open door' to resolve difficult system problems with a role in holding partnerships/organisations to account
- Ensuring there are mechanisms for strong clinical and care professional involvement in service redesign proposals

- Define clinical and professional roles, responsibilities and representation at the heart of decision making throughout ICS developments; ensuring leadership is resourced (funding, support and infrastructure)
- Reduce duplication and add value, with everyone working towards the same vision (making the system less complex)
- Develop and oversee Clinical and Care Professional Leadership by facilitating relationships and structures across the system at all levels
- Avoid duplication by ensuring distributed leadership is embedded in the right place and time with CPLG as a group providing the strategic umbrella

2.0 Remit

The CPLG will ensure delivery of its purpose through 3 strategic areas, aligned to wider ICS development and delivery:

i. To provide advice and assurance to the **ICB** on matters specifically relating to the **NHS and Provider Collaboratives:**
   a. Undertake clinical pathway and transformation reviews, ensuring strong clinical and professional involvement is evident as developments are progressed
   b. Support the work of the Provider Collaborative Leadership Board (PCLB) to ensure strong connections with collaboration at scale and underpinning structures such as the Delivery Boards
   c. Develop and ensure rollout of the Clinical Pathways Development Process (appendix 3) to ensure CPLG is utilised effectively in pathway developments and can make recommendations to the Population Health and Strategic Commissioning Committee and/or other groups as necessary

ii. To influence the work of the **ICP** and **Place Partnerships**:
   a. Influence the Integrated care strategy development by utilising CPLG effectively
   b. Support the work of the Integrated Place Executive to ensure strong clinical and professional distributed leadership is embedded consistently in our Place Partnerships, Local Place Alliances (inc. Social Care) and PCNs
   c. Ensure the ICP infrastructure is aware of the Clinical Pathways Development Process (appendix 3) and utilises the CPLG as set out where necessary/ appropriate
   d. Provide assurance to the ICP of strong CCP leadership and involvement in developments, ensuring broader health and care perspectives are taken into account

iii. To develop and embed system wide **Clinical and Care Professional distributed leadership** arrangements
   a. Responsible for delivery of the CCPL framework and associated action plan to ensure progress is being made
   b. Strengthen the distributed leadership model with the group acting as the glue to ensure all aspects brought together and embedded
   c. Facilitate strengthening of the strategic relationships and connectivity between CPLG and both Local Authorities, which has a shared purpose and is aligned to the integrated care strategy objectives
   d. Work with the Workforce Advisory Group to provide direction and facilitate the required cultural change

3.0 Roles and Responsibilities

The specific CPLG Chair and Vice Chair areas of responsibility can be found at Appendix 2.

All CPLG members are responsible for:

- Contributing to delivery of the overarching objectives as set out in these ToR

- Ensuring clinical and care professional ownership of changes and supporting leadership behaviours across the system
- Acting as ambassadors for JUCD; ensuring there are clinical and care professional advocates and involvement in service redesign proposals
- Ensuring that wider system clinical and care professional colleagues are kept informed and are engaged in developments as appropriate
- Providing the necessary intelligence and information to support the undertaking of accurate analysis to inform decision making

4.0 Delegated Authority

The scheme of delegation set out in the agreed clinical pathway development process will be followed for all clinical pathway and transformation proposals (see Appendix 3). The process defines the thresholds which CPLG can sign-off directly and what needs escalating to other ICS groups. CPLG will discusses the proposal in its meeting, and will provide one of the following recommendations:

a) Fully Supported – with comments and considerations
b) Partially supported – with recommendations and suggestions for further development
c) Not currently supported – Further additional work needs to be undertaken prior to CPLG being in a position to provide a considered view and make recommendations.

CPLG does not have the ability to make decisions which commit resources, however CPLG will make firm recommendations to relevant groups to inform decision making.

CPLG will make decisions on behalf of the system in relation to the clinical and professional leadership developments, working with other groups and committees as appropriate.

5.0 Accountability

CPLG is accountable to the Derby and Derbyshire Integrated Care Board (ICB) and the Derby and Derbyshire Integrated Care Partnership (ICP), through the CPLG Chair as a partner member on the respective Boards.

The Chair of CPLG will provide regular updates to highlight key considerations, recommendations and escalations to the ICB and ICP.

The Chair is responsible for proactively notifying the Chair of the ICB and ICP of any matters which need to be on the agenda of Board meetings, which are pertinent to the business of CPLG.

In addition, an annual report from CPLG will be developed to include progress and effectiveness in relation to system clinical leadership and engagement.

6.0 Membership and Attendance

The membership of CPLG will be kept under continual review to ensure it is evolutionary, depending on the ongoing needs of the system, and of the CCPL community. This will ensure the membership remains inclusive and representative, whilst balancing the value added both in the meetings and in enabling stronger connections with the wider ICS.

6.1 Membership

CPLG Chair
CPLG Vice Chairs (1)
CPLG Management Lead
AHP Council representative
Chief/Director of Pharmacy

Directors of Nursing from CRH, DCHS, DDICB, DHCFT, DHU, EMAS (2), UHDB
Medical Directors from CRH, DCHS, DDICB, DHCFT, DHU, EMAS (2), UHDB
General Practice Provider Board representative
LMC representative
Public Health representative (s)
Senior Social Care representative (s) (3)
Integrated Place Executive Clinical Lead
Local Dentistry Committee representative (4)
Psychological Therapies Representative (4)
Social Work Representative (4)

Notes:

(1) Vice Chairs may be members of CPLG in another capacity from the wider membership
(2) Recognising the scale of the service provider and necessity to connect with multiple ICSs and/or the nature of the discussion, EMAS members will be invited and included in the membership, but it is noted that they may not be able to consistently attend the meetings. Where there are pertinent agenda items for discussion then endeavours will be made to ensure representation
(3) Senior social care representatives are considered vital and important in ensuring a holistic view across the ICS and influencing the developments beyond the NHS in isolation. It is noted that this relationship is evolving to ensure value is added in the contributions. Representatives will remain as members of CPLG, but it is recognised that further clarity and confirmation will evolve.
(4) Members are included to provide a broader and more inclusive view and connectivity into wider clinical and care professional leadership developments. Developments are taking place to engage Local Pharmacy Committee and Local Optical Committees to recognise NHSE delegated function with effect from 1 March 2023/22

At this point in time, connectivity to the Provider Collaborative Leadership Board (PLCB) will be through the CPLG Chair attendance at the PLCB to create the strategic link, there is no request for a specific PLCB clinical lead in addition to this. Clinical and/or professional leads for the Delivery Boards reporting to the PCLB will be invited to CPLG subject to the agenda.

Where members are unable to attend a meeting, an appropriate deputy should be identified to attend in their absence.

By invitation:

- Programme Leads as required
- Delivery Board/ Programme Clinical Leads as required
- Any other representatives from across the system as required

All members will be required to provide organisationally agnostic clinical and care professional views in discussions.

6.2 Attendance

Members will be expected to attend 70% of the planned meetings.

It is recognised that, for a forum of this nature, there may be difficulties in attendance due to clinical commitments, therefore the Chair must be satisfied that there are enough representatives in the room to give a good cross-system balanced opinion for a firm recommendation to be made.

7.0 Meeting Arrangements and Frequency

Meetings will be held monthly for duration of 1.5-2 hours; extraordinary meetings may be arranged if required to consider matters in a timely manner.

All meetings will be held via MS Teams to facilitate attendance, except for development sessions which will be held face-to-face on occasion.

Where necessary members will be required to respond to ‘virtual’ electronic communications owing to timescales.

The Chair and Vice Chairs will be responsible for jointly agreeing the agenda; ensuring matters discussed meet the objectives as set out in these ToR.

Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing.

Papers will be circulated at least 4 working days prior to the meeting; meetings will be clearly minuted and circulated promptly following the meeting to all members.

There will be a standing agenda item at the end of each meeting to check the objectives have been met and review effectiveness of the discussions.

8.0 Quoracy

Quoracy will be at least one representative, as a minimum, from each of the sectors below:
Acute
Community services
Mental health
Primary Care
Commissioners
CPLG Management Lead
Local Authority - Public Health/ Social Care (depending on the subject matter)

9.0 Behaviours and Decision Making

9.1 Behaviours

CPLG members will:

- Model collective leadership by acting as system ambassadors to ensure the common purpose of ICS is delivered
- Facilitate broader clinical and professional leadership, which is recognisable, connected, representative and diverse
- Value everyone's contributions; actively listening and enabling people to be heard and having trust that their opinions and decision making will make a difference for the mutual benefit of our population
- Act as facilitators to engage respective organisations in the direction of travel
- Support each other to address barriers to system integrated care transformation
- Be inclusive and engaging with all levels of the system
- Demonstrate consistent and effective messaging and communication
- Be fair, open and transparent
- Make proactive and positive contributions

9.2 Decision-Making

The CPLG has no powers other than those included in the ToR

The group will seek to reach consensus in deciding recommendations. Where consensus cannot be reached, views which oppose the majority view will be recorded and presented with the report to the relevant committee to ensure transparency.

Members are expected to act as facilitators, providing effective communication for the programme to engage their respective organisations in the developments, modelling collective leadership.

Members are expected to provide information as necessary to support the undertaking of accurate analysis to inform developments.

9.2.1 Urgent Decisions

The CPLG may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the meetings of the Committee and in relation to which a decision must be made prior to the next scheduled meeting.

Where an urgent decision is required, a supporting paper will be circulated to all members. To reach a consensus view or make a decision the members may meet either in person, via video conference or communicate by email to take an urgent decision. The quorum, as described above, must be adhered to for urgent decisions.

In such circumstances, a minute of the discussion and decision will be taken by the secretary and will be reported to the next meeting for formal ratification.

10.0 Equality and Diversity

Members must demonstrably consider the equality and diversity implications of ant decisions and recommendations made.

11.0 Managing Conflicts of Interest

Members of ICS governance groups shall adopt the following approach:

Members must ensure that they continue to comply with relevant organisational policies / governance framework for probity and decision making.

a register of interests will be recorded and maintained. This will be reviewed annually to ensure accuracy, in the intervening periods members should declare any unregistered interests pertinent to the agenda on an on-going basis. Members will be responsible for notifying of any changes to their respective declarations as and when they occur.

In advance of any meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals.

The Chair will take overall responsibility for managing conflicts of interest pertinent to agenda items as they arise; any such declarations will be formally recorded in the minutes of the meeting.

The Chair will determine how declared interests should be managed, which is likely to involve one the following actions:

a. Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions.
b. Allowing the individual to participate in the discussion, but not the decision-making process.
c. Allowing full participation in discussion and the decision- making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

12.0 Secretariat and Administration

The CPLG shall be supported with a secretariat function which will include ensuring that:

Attendance of those invited to each meeting is monitored

Records of members' appointments and renewal dates are maintained so that the Board is prompted to renew membership and identify new members where necessary.

Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.

The Chair is supported to prepare and deliver reports to the Board.

CPLG is updated on pertinent issues/ areas of interest/ policy developments.

Action points are taken forward between meetings and progress against those actions is monitored.

13.0 REVIEW

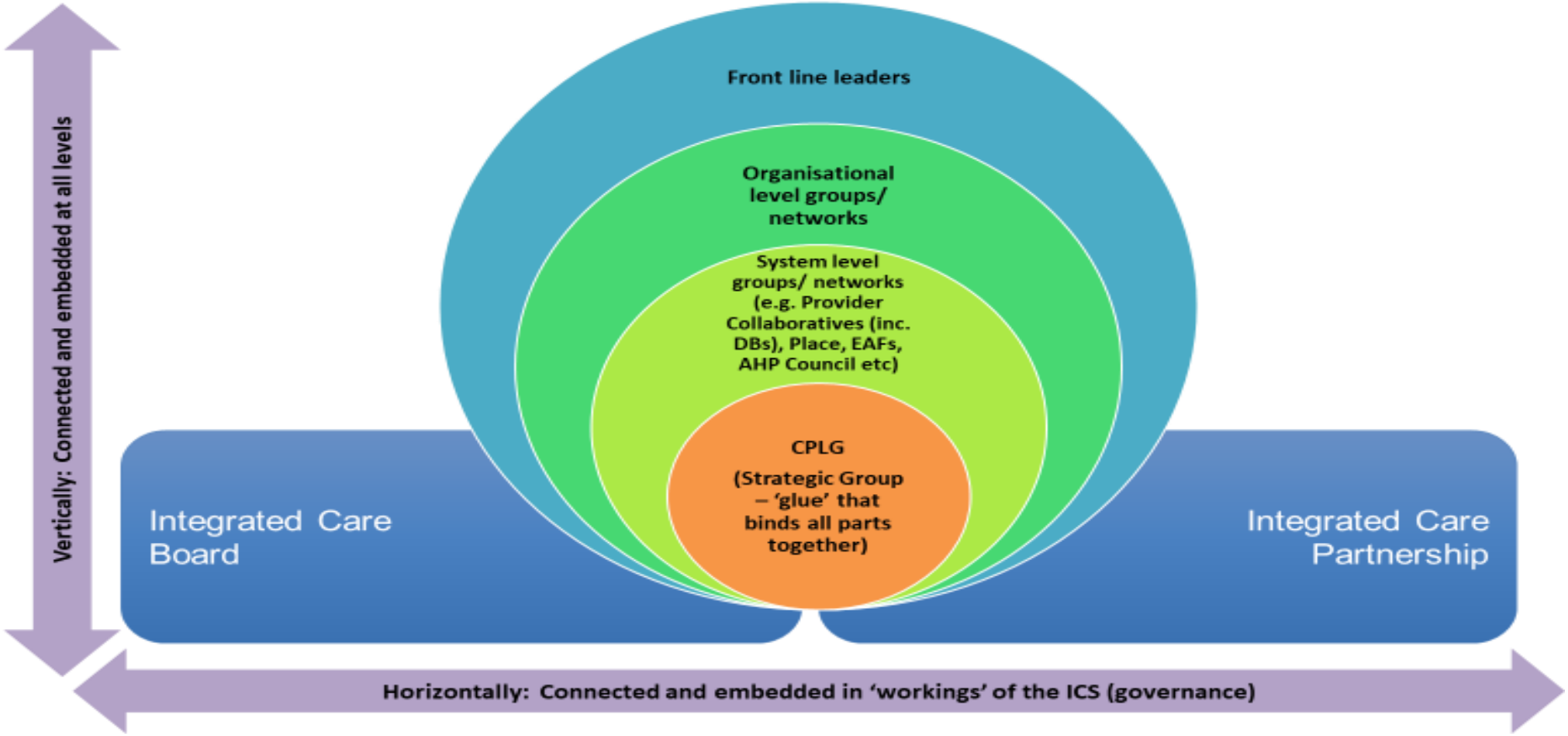
These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board and ICP Board for approval.

To facilitate continual learning and development, a 6-monthly review will take place to ensure that CPLG continues to be effective in discharge of its functions.

Reviewed:	CPLG	20 December 2022
Approved:	NHS Executive	[Insert Date]
	ICB Board	[Insert Date]
	ICP Board	[Insert Date]
Review Date:		[Insert Date]

APPENDIX 1

Our Agreed Clinical and Care Professional Leadership Model - distributed clinical and Professional Leadership which is connected at all levels in JUCD



APPENDIX 2

CPLG Roles and Responsibilities: Agreed at CPLG SLT 12 July 2022 and CPLG 2 August 2022

The overarching CPLG objectives (previous slide) have been distributed amongst the leadership team. These areas of responsibility have been aligned to the future agenda structure; noting that there will be an inevitable element of cross over. **Wider CPLG leadership will be responsible for supporting the Chair and Vice Chairs in delivery of the overarching objectives.**

Chair/ Vice Chair	Areas of responsibility
Chair: Avi Bhatia	• Convenor of CPLG with responsibility for effective functioning and development of the group • Making recommendations and providing assurance to the ICB and ICP; ensuring the CPLG considerations are taken into account as necessary • Influencing the Integrated care strategy development by utilising CPLG • Facilitate strengthening of the strategic relationships and connectivity between CPLG and both Local Authorities, which has a shared purpose and is aligned to the integrated care strategy objectives • CPLG link to Strategic Population Health & Commissioning Committee, ensuring recommendations made by CPLG are taken into account in commissioning decisions
1 Vice Chair: (NHS) Provider Collaborative Link – Ben Pearson	• Deputy for the Chair on the ICB Board as required • Leading on clinical pathway and transformation reviews and strong clinical and professional involvement is evident as developments are progressed • Support the work of the Provider Collaborative Leadership Board (PCLB) to ensure strong connections with collaboration at scale and underpinning structures such as the Delivery Boards • Develop and ensure rollout of the Clinical Pathways Development Process to ensure CPLG is utilised effectively in pathway developments and can make recommendations to the Population Health and Strategic Commissioning Committee and/or other groups as necessary • Supporting leadership developments through the CPLG Leadership Team – connecting to relevant system groups (e.g. Place, Provider collaboration, People and Culture)
1 Vice Chair: ICP & Place link – Penny Blackwell	• Deputy for the Chair on the ICP Board as required • Acting as the conduit with the ICP to ensure CPLG is connected to and influencing the ICP Integrated Care Strategy developments • Support the work of the Integrated Place Executive to ensure strong clinical and professional distributed leadership is embedded consistently in our Place Partnerships, Local Place Alliances (inc. Social Care) and PCNs • Ensure the ICP infrastructure is aware of the Clinical Pathways Development Process and utilises the CPLG as set out where necessary/ appropriate • Working with the Chair to provide assurance to the ICP of strong CCP leadership and involvement in developments, ensuring broader health and care perspectives are taken into account • Supporting leadership developments through the CPLG Leadership Team – connecting to relevant system groups (e.g. Place, Provider collaboration, People and Culture)
1 Vice Chair: CCPL Development – Lucy Smith	• Leading the leadership developments through the CPLG Senior Leadership Team – connecting to relevant system groups (e.g. Place, Provider collaboration, People and Culture) • Ensuring all aspects of delivery of the CCPL framework and associated action plan to ensure progress is being made • Strengthen the distributed leadership model with the group acting as the glue to ensure all aspects brought together and embedded • Work with the Workforce Advisory Group to provide direction and facilitate the required cultural change
1 Vice Chair: Integrated Care Local Authority - Vacant	To be developed to maintain a rounded, ICS-view

Joined Up Care Derbyshire

APPENDIX 3

Clinical Pathways Development Process

(Approved by the Population Health & Strategic Commissioning Committee: 10 November 2022 and the Provider Collaborative Leadership Board: 30 November 2022)

1. Purpose

This paper seeks to clarify the JUCD clinical pathways development process, following recent discussions at Clinical and Professional Leadership Group (CPLG) regarding approval of Expert Advisory Forums (EAF) proposals, and proposes a clear, streamlined route for approval and enactment of proposals generated at specialty/pathway level.

It is important to note that this paper does not aim to define the wider system governance arrangements, which are still evolving. The focus of the approach set out below is to define a specific element regarding pathway developments that are an important part of the whole. CPLGs role in both the approach described in this paper and with the wider ICS governance will be crucial and therefore for context Appendix A describes a wider view of CPLG's developing relationship with other JUCD system elements. In this context, this paper will be reviewed after 12 months, as the wider ICS system governance evolves further.

2. Background – Case for Change

Expert Advisory Forums (EAFs) are one of a series of specialty/pathway level groups that exist within the JUCD governance. EAFs specifically are intended as forums where primary, community and secondary clinicians can come together to develop service improvements within a particular specialty. There are steering groups in a number of other pathways (e.g., LTCs, MSK) which perform a similar function to EAFs.

The governance route through which EAFs' recommendations is enacted is not clear. Nominally, EAFs report to the Outpatient Delivery Board, although their work often extends well beyond outpatient services. Other comparable groups report through different Delivery Boards.

A recent issue has highlighted this lack of clarity – the Dermatology EAF proposed the adoption of an Advice & Guidance model in both CRH and UHDB, however this led to concern from elements within the wider GP community who felt that there could be significant impacts upon primary care services, and that adequate engagement had not taken place.

Discussion therefore took place at the May and June 2022 CPLG meetings (and in a supporting pre-meeting) to determine what an appropriate model could be, which would incorporate adequate engagement for clinical, operational and financial matters; not place undue bureaucracy or delays in the way of proposed developments; and be both streamlined and link into current known wider system governance. These discussions, with senior primary, community and secondary care representation, form the basis of this proposal. Following the initial development through CPLG, the proposal has been considered by other system leads to seek their feedback and inform any subsequent refinement.

Additionally, there is scope alongside the main proposal for CPLG to influence the groups which feed into the model. System priorities, based upon population health data, should influence the range of EAFs and equivalent groups in the system. At the same time, there are instances of potential duplication, with multiple system-level groups for some individual specialties – as an example, ENT clinicians have supported a proposal to concentrate all system ENT work through the EAF. There is scope to create greater simplicity and consistency in these groups. CPLG should be in a position to support this drive to reduce duplication, and to be proactive in system design.

3. Proposed Model

It is intended that the proposed model:

- Offers a streamlined and simplified governance route providing a clear clinical and professional view
- Supports collaboration and co-production
- Ensures communication and consultation with stakeholders across the system, including patient engagement
- Offers the ability to make recommendations to the system from a clinical and care professional perspective
- Enables the individuals in CPLG to work with their own organisations to aid enactment and transformation

Description:

A **Scheme of Delegation** should be in place, to determine what CPLG can sign-off directly and what needs escalating. CPLG should be able to immediately sign off lower risk initiatives or those with little or no cost, or little or no shift or allocation of resource. The Scheme should determine the exact thresholds. This will aid delivery, enactment and ownership as well as aiding transformation in stakeholder groups.

Appendix B sets out the high-level checklist of considerations which underpin the steps defined below; this is based on the scheme of delegation thresholds.

Step 1: It is proposed that EAFs and other comparable groups (having sought appropriate expert input) send their output to CPLG for ratification. The EAF / equivalent needs to have consulted relevant subject matter experts (e.g., finance, workforce, digital, estates) and stakeholders from across the system (incl. patients) before presenting to CPLG. This is to include discussions among all relevant professional groups (such as General Practice, Allied Health Professionals and social care) to evidence that alternative models of service delivery have been considered where appropriate and any wider impacts beyond the immediate scope have also been considered. A clear process for seeking of relevant input, and for recording this to assist CPLG with their decision making, will be communicated to EAFs and equivalents, and it would be expected that this is adhered to, in order to secure CPLG sign-off.

The seeking of expert input should incorporate e.g., reasonable engagement on primary and secondary care opinions although this does not need to be through a formal group (e.g., LMC or GP Provider Board). The development of a standard process / template is recommended, to ensure that EAFs and equivalent groups can demonstrate the engagement and rationale behind their proposals in a clear and structured way. This is important to ensure any advice and/or concerns raised during the development of proposals is evidenced and addressed.

Within this step and prior to seeking formal CPLG support, if necessary, the CPLG can also be utilised to gain a broader system clinical and professional objective view to test any conceptual ideas. However, that would not preclude the need to then undertaken the specific engagement set out above.

Step 2: CPLG then discusses the proposal in its meeting, and then will provide one of the following recommendations:

d) Fully Supported – with comments and considerations
e) Partially supported – with recommendations and suggestions for further development
f) Not currently supported – Further additional work needs to be undertaken prior to CPLG being in a position to provide a considered view and make recommendations.

Step 3: For proposals where there are no commissioning decisions required (i.e. no resource implications, wider system impacts/risks), CPLG will be in a position to support implementation. For all other proposals where initiatives require a shift in allocation of resource, and / or with wider system implications, and / or carrying higher risk, the appropriate commissioning forum will make the necessary decisions. This will be informed by CPLG's

recommendations having undertaken an initial review of the proposal; noting CPLG would not be able to consider any financial implications and would therefore consider the merits from a model of care perspective only and would provide that view to the necessary commissioning decision making group.

One sign-off route from CPLG would be to the JUCD Provider Collaborative (i.e., the Provider Collaborative Leadership Board, PCLB, or its immediate operational sub-committee). The Provider Collaborative will have delegated authority for significant amounts of the commissioning function previously carried out by CCGs and is likely to be resourced to enable this. Additionally, the Provider Collaborative will have prime delivery responsibility for the system and will be able to ensure that EAF initiatives will help to meet that delivery.

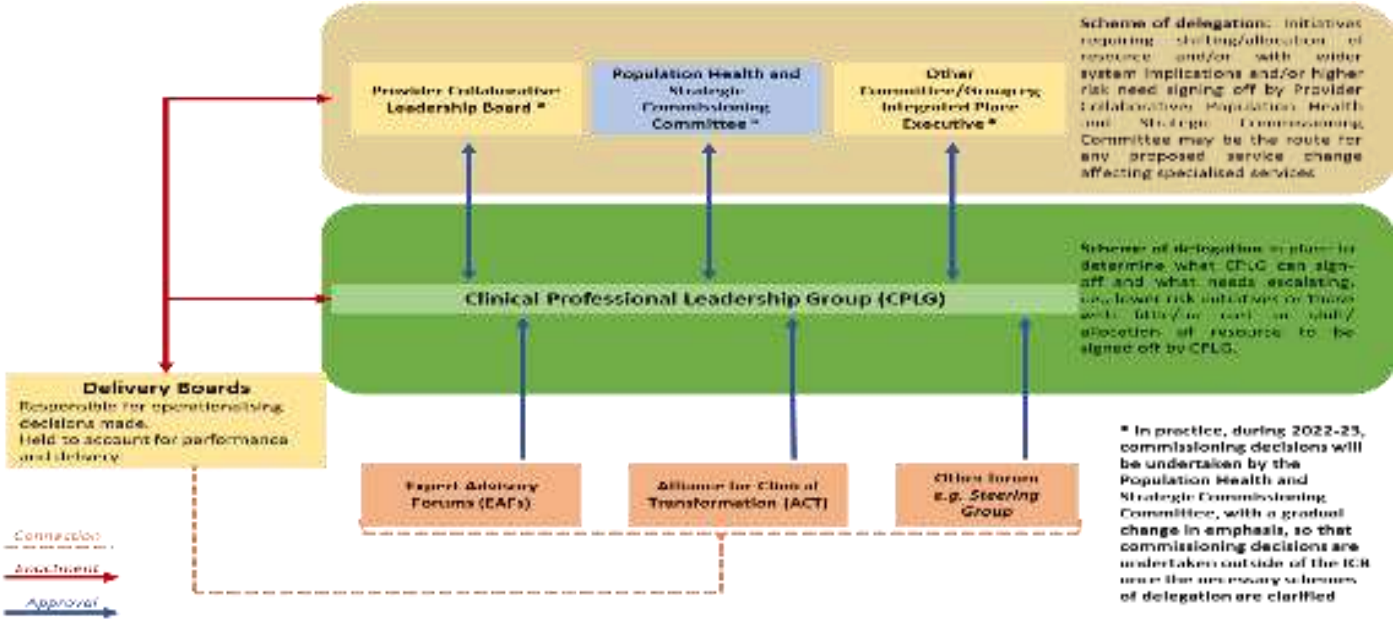
In other cases, Population Health and Strategic Commissioning Committee may be the route for any proposed service change, e.g., anything affecting specialised services or if there are particularly wide-reaching system implications – the Scheme of Delegation should cover this. Alternative routes may develop as the ICS matures.

In practice, during 2022-23, it is likely that commissioning decisions will be undertaken by the Population Health and Strategic Commissioning Committee. It is expected that there will be a gradual change in emphasis over time, so that 'traditional' commissioning routes are undertaken outside of the ICB (e.g., provider collaboratives) once the necessary schemes of delegation are clarified. Therefore, as the broader arrangements develop, so too will the extent to which there is an ability to commit resource to CPLG recommended schemes.

It is important to note that the focus of these proposals relate more specifically to the NHS specialty level pathways and therefore are more closely aligned to the provider collaboratives as described in the diagram below. It is recognised that the other commissioning routes, as they develop will include Place Partnerships but at this time that is not within the scope of this proposal. It will however be necessary to understand such delegation as it evolves so that end to end pathways which are closely related to Place Partnerships delivery are enabled and supported through CPLG with a similar/consistent approach.

Step 4: Delivery / enactment of initiatives will normally sit with the relevant JUCD Delivery Board, likely to be within the Provider Collaborative and therefore with clear accountability for system performance and delivery. This paper does not cover the Delivery Board Terms and composition, but it is noted that a greater and appropriate clinical and professional presence on the Delivery Boards may help to ensure greater alignment with CPLG.

Schematic: The diagram below illustrates the proposed model, per the above description:

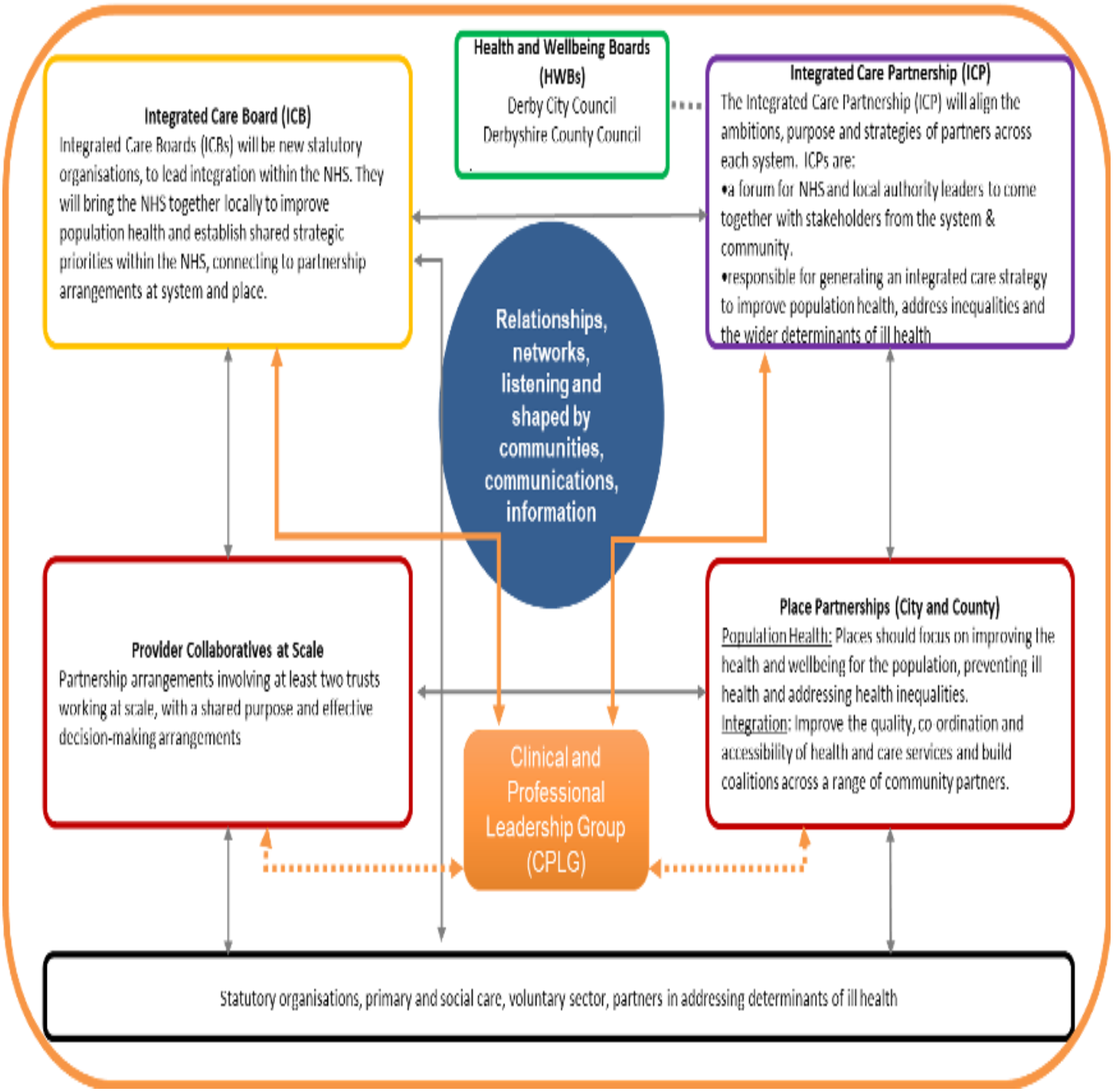


Clinical Pathways Development Process: Appendix A

The diagram below (adapted from the JUCD ICS System Development Plan refresh, May 2022) shows a wider view of CPLG's developing relationship with other JUCD system elements. This is presented for context and does not directly impact the proposals above. It is recognised that JUCD system governance is work in progress.

Component parts of the JUCD ICS: CPLG Relationship

The diagram below aims to demonstrate the CPLG's interface and positioning within the wider ICS 'wiring'. Note this is for illustrative purposes only – not formal governance arrangement. The diagram is described at a point in time and may be subject to change.



Clinical Pathways Development Process: Appendix B

Development Thresholds and Checklist of Considerations

Development Thresholds

Threshold 1: Organisation level

Does the proposal stay within the boundaries of one statutory organisation without significant resource implications?
(i.e. does not impact upon patient flow and / or resource usage outside the organisation)

Changes of this nature can usually be enacted without the need to connect with wider system developments and/or seek support from CPLG, unless it is felt that the proposal would benefit from a wider system view to aid implementation and/or other considerations, in which case CPLG would be happy to support

Threshold 2: System level

Does the proposal cross organisational / sector boundaries? *(i.e. impacts upon patient flow between e.g. primary and secondary care)*

Formal patient and public engagement and/or consultation where appropriate, may not usually be required for proposal's falling in this threshold. Refer to the JUCD Engagement Governance Guide

Threshold 3: Large-scale Change

Does the proposal involve large-scale service change?
(e.g. transfer of personnel / significant workforce change, major capital development, crosses ICB footprints)

Patient and public engagement and/or consultation where appropriate, will be required for proposal's falling in this threshold. Refer to the JUCD Engagement Governance Guide (Guide to working with people and communities » Joined Up Care Derbyshire***)***
Contact ddicb.engagement@nhs.net

Checklist of Considerations

These considerations are designed to help you think about the various aspects which would build a strong proposal for CPLG to provide a view on

Have you considered alternative approaches which could provide greater benefits ***and*** would broaden the scope of the proposal? **If yes, consider areas below in the developments**

- Have you thought about how this addresses the JUCD Quadruple aim?
- Have you engaged with and captured the viewpoints and perspectives of a wide range of multi-professional stakeholders from across the system?
- Can you evidence considerations against the 7 pillars of governance (linking this to the System Quality Group Quality & Performance Framework):
  - Involvement of service users (Engagement and health inequalities / EQIA)
  - Staffing and Staff Management (Engagement, workforce planning, Memoranda of Understanding between employing organisations)
  - Evidence based best practice
  - Use of Information and Resources (Data & Digital, Finance, Estate, contracts) *Have you involved subject matter experts (e.g., finance, workforce, digital, estates, medicines management) in the development of the proposals?*
  - Education and Training (Skills and competencies)
  - Risk Management (Linked to system risks) *Are there any significant risks associated with this change/ risks of not doing it?*
  - Audit, Quality Improvement and Learning (Outcomes expected and performance monitoring)
- Is the proposal in line with JUCD Medicines Guidelines (JAPC) and/or Clinical Policies (CPAG) or otherwise this will require further engagement with the ICB Medicines Management and Clinical Policies Team

It is recommended that you consider linking in with the Joined Up Improvement Network for additional support: ddicb.PMOSupport@nhs.net