Joined Up Care Derbyshire

Appendix A: Supplementary Information: Clinical and Care Professional Leadership (CCPL) Developments - Progress and Forward Plan

1 December 2022

NHS | The Derbyshire VCSE sector Alliance | Derby City Council | Derbyshire County Council

Progress against our CCPL Framework (summary) April 2022 to November 2022

The following tables provide a summary of the CCPL framework development themes which emerged through discussions with CPLG and the focus group sessions. These areas were agreed as the key development areas at the CPLG meeting on 5 April 2022. The 5 principles and alignment to the full framework can be found in Appendix 1.

Development Theme	What will be different?	What have we achieved?	Priorities for the next 6 months
Model/ Narrative	We have a clear model and narrative that resonates and is applicable at all levels; enabling a cultural shift towards a collective vision/set of priorities which informs decision making	• Co-produce our CCPL framework in response to the national guidance, which includes the vision and model for distributed clinical and care professional leadership for JUCD and the role of CPLG within that. We have done this through various forums (inc. Shadow Provider Collaborative Leadership Board, Integrated Community Place Board, Place Development Sub-Committee, People and Culture Board, GP Provider Board and the Alliance for Clinical Transformation (ACT); all feedback incorporated into our model and framework and further informed by our launch event in May 2022. • Considered to be one of the strongest system CCPL frameworks. • Launch event in May with circa 150 attendees, key messages informed the design of the October event	• Continue to review language being used to ensure it is inclusive, relevant and applicable across the system - including Local Authorities and the voluntary sector – build a consistent understanding of what is meant by distributed CCPL • Consider how the model speaks to/represents operational leaders – continue to socialise and test further
Distributed leadership	• Clinical and care professional voices are heard and listened to, enabling dialogue across professions and developments with the ability to influence wider JUCD priorities • Interdependencies and synergies across the system are recognised, including how we connect, support people and the roles of individual organisations	• We have strengthened the role of CPLG as the 'glue' that binds distributed leadership together (this is not about having everyone around the CPLG table but how that system leadership group facilitates beyond the group itself); recognising that distributed leadership already happening in the system space and the approach is to connect and recognise this more effectively where appropriate • Undertaken an initial mapping exercise to understand what is already established and where clinical and professional leaders are driving forward developments • 2nd Engagement event held in October with circa 100 attendees to further develop consistent understanding of what good distributed leadership looks like by using positive experiences/ leadership in action • Key message from the May event was that people needed greater emphasis on practical tools/methods to recognise their distributed leadership roles – the session was designed initiate the coproduction of an applied leadership offer	• Build trusted, open relationships with wider networks; by tapping into existing networks and ICS developments (including Place and Provider Collaboratives); further develop mapping exercise and look at opportunities for alignment and refinement • Continue to facilitate broader clinical and professional leadership which is connected and representative • Provide the necessary tools to support individuals to step into the leadership space. 13 individuals volunteered to develop the offer at the Oct event. 2 focus groups have been arranged for the end of Nov and early Dec to test out content and delivery, with the aim to get offer ready from April.

Progress against our CCPL Framework (summary) April 2022 to November 2022

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Development Theme	What will be different?	What have we achieved?	Priorities for the next 6 months
Diversity & Inclusivity	• Mechanisms are in place to ensure the broadest engagement across the system, including Local Authorities and the voluntary sector to have an impact on the wider determinates of health • Subsequent feedback from NHS Elect colleagues to note national emphasis being place not only on diversity and inclusivity from a broad range of professional leaders but also leaders reflective of all protected characteristics. Our leaders will reflect EDI	• Reviewed CPLG membership to include a broader range of professionals	Work through the People Service Collaborative to embed the CCPL distributed leadership model and ensure that it is connected with the 7X5 EDI workstream
Leadership Roles	• We will have defined clinical and care professional roles, responsibilities and representation at the heart of decision making throughout ICS developments • Leaders will act as ambassadors connected to CPLG	• Chair of CPLG is a member of both the ICB and ICP • Reviewed membership of CPLG to ensure broader range of professionals • Agreed 3 vice chairs with defined areas of responsibility (placeholder for LA vice chair to ensure all aspects of the ICS are covered in the future and not solely NHS) • Aligned CPLG senior leadership (Chair and Vice Chairs) with component parts of the system e.g. members of PCLB, Integrated Place Executive, Population Health and Strategic Commissioning Committee, Workforce Advisory Group, System Quality Group • Mapping undertaken to create better understanding of CPLG connectivity and visibility across system governance and developments (see appendix 2)	• Work with Local Authority colleagues to form a plan to create a stronger social care leadership voice in the CPLG space (with clear objectives and shared purpose aligned to the Integrated Care strategy) • Work with clinical pathway groups e.g. EAFs to create clarity about the mandate, objectives, resources and support for leadership roles

Progress against our CCPL Framework (summary) April 2022 to November 2022

The following tables provide a summary of the CCPL framework development themes which emerged through discussions with CPLG and the focus group sessions. These areas were agreed as the key development areas at the CPLG meeting on 5 April 2022. The 5 principles and alignment to the full framework can be found in Appendix 1.

Development Theme	What will be different?	What have we achieved?	Priorities for the next 6 months
Leadership Development	Working with the Workforce Advisory Group we will: • Ensure new leaders are identified and nurtured by providing broader system leadership opportunities • Ensure leadership capabilities and behaviours relevant to all leaders are embedded consistently • Create an environment and culture which gives leaders a voice and freedom to act beyond the constraints of organisational boundaries • Ensure every professional group has some population health understanding	• Through the CCPL engagement events we have started to shape a better understanding of leadership needs and established a working group to develop a system applied leadership offer. The offer will build on what is already in place (e.g. mentorship and coaching) • Agreed a CCPL leadership behaviours framework to help clinical and professional leaders at all levels (not just those in formal leadership roles) to think and lead differently (see appendix 3)	• Develop stronger links with system OD so CCPL leadership development is considered part of the whole and not as a separate entity • Promote and utilise initiatives/development opportunities already happening in the system (e.g. Clinical Directors forums to be opened up to other clinical and professional colleagues including primary care and PALM in Place Partnerships) • CPLG development to be included as part of wider system OD
Support	Leaders are provided with the necessary time and resource (including aligned management support)		• Confirm resourcing of strategic leaders • Review what we have now to determine resource available, identify gaps and realign to new ways of working/ priorities • Develop plans to devolve leadership oversight and resource (namely GP Clinical Leads currently aligned to EAFs) to CPLG • Create learning networks and peer support forums

Progress against our CCPL Framework (summary) April 2022 to November 2022

The following tables provide a summary of the CCPL framework development themes which emerged through discussions with CPLG and the focus group sessions. These areas were agreed as the key development areas at the CPLG meeting on 5 April 2022. The 5 principles and alignment to the full framework can be found in Appendix 1.

Development Theme	What will be different?	What have we achieved?	Priorities for the next 6 months
Comms & Engagement	• Knowledge and understanding of the ICS, its vision and priorities are clearly articulated to give leaders confidence in the new arrangements and the value their contributions add to the system • Greater visibility, engagement and awareness between clinicians, professionals, managers and the public • Simplified processes with better connectivity between developments taking place at different levels to reduce duplication and complexity	• 2 system wide engagement events held to shape our direction of travel/ framework, engage and seek views on key issues to inform future developments and to share information in relation to CCPL le in the context of the wider ICS for example). Extremely positive feedback received with a desire for the events to continue regularly • CPLG updates now included regularly in JUCD newsletters	• Develop a communication and engagement strategy/approach to create consistent messages across the system and broaden understanding of the ICS • Consider other ways to support clinical and care professionals to have a better understanding of the system and think 'system first' • Actively seek the views of frontline colleagues, for example through regular engagement exercises and annual pulse checks • Develop NHS Futures as a platform for sharing information
CPLG Role	In the context of our agreed model and the development discussions, the role and positioning of CPLG will be strengthened to genuinely act as the 'glue' that binds the distributed CCPL developments together and acts as a strategic system group to advise the wider ICS	• Strengthened the role of CPLG and how it fits within future governance arrangements (including the ICB, ICP, place-based partnerships, Provider collaboratives and Delivery Boards) and any sub-committees; being clear about what we do and what others do and how we all connect • Developed a clinical pathways development process which has been approved by the PHSCC and PCLB to provide consistency, with recommendations made by CPLG accepted and recognised in decision making	• Seek approval of revised TOR (separate paper) • Substantive Chair to be in place from 1 April 2023 (separate paper) • Continue to review and develop role and functioning of CPLG within the wider ICS developments • Seek system support to undertake NHSE Support offer in February, focusing on strategic decision makers with the aim of embedding CPLG positioning in the system • Develop plan with the Local Authority for Senior Social Care representative and input to CPLG by considering merit of potential support offer from NHSE delivered by Sir David Pearson

Strengthened CPLG approach: Summary of considerations (Aug 22 – Nov 22)

From August onwards the CPLG agenda was aligned to ICS developments, to reflect 3 facets:

1. ICB (NHS)
2. ICP
3. CCPL Developments

The purpose of this change is to differentiate agenda items where there would be greater benefit for Social Care colleagues to be part of the discussions in a more meaningful way. We also established the CPLG Senior Leadership Team which now meets fortnightly and changed the formal CPLG meetings to monthly with extended timings (previously met for 1hour each fortnight).

Date	Item:	Agenda 'facet'	Presenter:	Overview:	CPLG Recommendations:
15 November 2022	Provider Collaborative Leadership Board Priorities	ICB (NHS)	Tamsin Hooton, Programme Director	An overview of the potential PCLB priority areas and initial thinking in relation to fragile services and how they inform prioritisation	CPLG agreed it would be beneficial to hold a wider workshop discussion in relation to fragile services early in the new year and would support the development of that.
15 November 2022	Cancer Referral Optimisation	ICB (NHS)	Monica McAlindon, Head of Cancer	To enable clinical and professional discussion regarding Cancer Referral Optimisation with regards to FIT uptake in particular	CPLG agreed priority audits needed to be undertaken to facilitate peer to peer discussions in referral practices and to explore the options for primary/secondary care joint education focusing on cancer referrals
20 September 2002	CPLG Terms of Reference	CCPL Development	Sukhi Mahil - JUCD Assistant Director	Revised CPLG Terms of Reference shared with members for comment and approval. CPLG connectivity to system governance also shared to aid understanding of where CPLG now fits.	CPLG **approved** the amended Terms of Reference, with the inclusion dental, pharmacy and ophthalmology colleagues and ensure representation at CPLG to future proof ahead of March 2023, and noted the connectivity within the wider system governance
20 September 2022	Headache Pathway	ICB (NHS)	Dom Moore, Deputy Chief Pharmacist (UHDB)	Amendments made to pathway since initially being presented to CPLG in February 2022	CPLG noted the pathways but further development was required re: engagement with primary care and CRH before full support could be given
2 August 2022	GP with Extended Roles Proposal	CCPL Development	Kath Bagshaw, Deputy Medical Director DDICB and GP in Erewash	Feedback sought on pilot roles proposal - 3 x roles at CRH and 3 x roles at UHDB. The pilot aims to improve GP retention, particularly for mid-career GPs, and also aims to improve the primary and secondary interface and quality of referrals	CPLG **supported** the pilot, noting that if the only outcome is improved GP retention, that is a great positive. If the pilot supports knowledge/skill sets coming back into community, that's an even better result. KB will feedback outcomes of pilot at a future CPLG
2 August 2022	Primary & Secondary Care Interface	CCPL Development	Andy Mott, GP and Interim Chair of GP Provider Board	Document developed by Alliance for Clinical Transformation (ACT) aiming to improve interface between primary and secondary care. The document details guiding principles on behaviours all professionals should be undertaking to improve communication and keep the patient at the centre of decision making	CPLG **supported** the document, noting its relevance to the wider system. CPLG members took away actions to socialise the model with colleagues across the system
2 August 2022	CPLG Terms of Reference	CCPL Development	Sukhi Mahil - JUCD Assistant Director	Revised CPLG Terms of Reference shared with members for comment and approval; incorporating the Vice Chair roles and responsibilities	CPLG members approved the Vice Chair roles/responsibilities and were happy for these to be embedded into the revised CPLG Terms of Reference

Strengthened CPLG approach: Summary of considerations (Aug 22 – Nov 22)

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Date	Item:	Presenter:	Overview:	CPLG Recommendations:
28 June 2022	Dental Services for the ICS	Rami Khatib, Chair of the Derbyshire County Local Dental Committee	RK shared updates on how dentistry sits in the ICS and to share insight into the pressures dentistry is currently facing, and the wider role dentistry has in the populations overall health	CPLG **noted** the presentation and reflected on the challenges shared across the system
14 June 2022	Clinical Governance Model	Avi Bhatia - CPLG Chair	Discussion around the development of a clinical governance model to ensure appropriate and system-wide engagement before pathway changes are implemented.	**Agreement** by CPLG for the development of a clinical governance model that avoids duplication, has some input into finance and other key considerations, and has a clear route of where recommendations feed into and how to escalate.
17 May 2022	Dermatology Advice & Guidance	Hal Spencer, Interim Chief Executive (CRH)	Test case for clinical governance and decision making processes across the ICS - ensuring appropriate clinical engagement across the system	It was agreed that the dermatology advice and guidance pathway would be reviewed again later in the year. Further discussions would be had around increasing the GP workload as a result of the pathway change. This case triggered the development of the Clinical Pathway Development Process which has since been approved by the PHSCC.
17 May 2022	JUCD Quality Strategy	Helen Hipkiss, Director of Quality (DDICB)	Draft JUCD quality strategy shared with colleagues for comment and support	CPLG provided feedback and **support** of the strategy. HH took away an action to collate comments to inform a further version of the draft strategy before re-circulating for final comment virtually, ahead of the final version being taken to the Shadow ICB Board in June 2022
3 May 2022	CCPL Framework Development	Sukhi Mahil - JUCD Assistant Director	Vice Chair arrangements to be confirmed in context of wider CCPL leadership requirements and system developments	CPLG **confirmed** preference towards option 2 (2x Vice Chairs – I NHS facing and 1x ICP facing) CPLG members were asked to put forward their expressions of interest in the roles.
3 May 2022	Post-Covid Service	Steve Lloyd: Executive Medical Director (DDCCG)	CPLG were updated on the new Post-Covid Service pathway, which now encompasses rehabilitation as well as assessment	CPLG **supported** the approach being taken
5 April 2022	CCPL Framework Development	Sukhi Mahil - JUCD Assistant Director	An overview of the CCPL framework development was provided and plans for launch event on 10 May to socialise and develop further were discussed. Chair arrangements were considered	CPLG **approved** the CCPL framework, direction of travel and proposals for the Chair arrangements. CPLG members encouraged to continue endorsing and promoting CCPL.
5 April 2022	Virtual Wards	Reeve Palmer, Commissioning Manager (DDCCG)	Virtual ward proposal was shared for comment/support	Feedback provided around staffing, clear lines of clinical accountability and consideration of digital exclusion in the development of virtual wards. Feedback was also given around the need to build on existing programmes, such as Team Up, and to ensure appropriate system-wide engagement
22 March 2022	Liberty Protection Safeguards	Michelle Grant, Designated Nurse Safeguarding Adults/MCA Lead	CPLG were informed of the transition from the Deprivation of Liberty Safeguards Framework to the Liberty Protection Safeguards - implications for clinical and care professional colleagues were discussed	CPLG colleagues **noted** the update
22 March 2022	Strategic Clinical Planning	James Crampton, Interim Executive Medical Director (UHDB)	CPLG were asked to support with the UHDB review of strategic clinical planning	CPLG **supported** the UHDB Clinical Strategy refresh and agreed there was a need for wider clinical and professional input to be included (e.g. primary care); this was considered a great opportunity to see how the system works together across partner organisations. It was noted that in the future there was a need to consolidate organisational clinical strategy developments.
8 March 2022	CCPL Framework Development	Avi Bhatia - CPLG Chair & Sukhi Mahil - JUCD Assistant Director	CPLG were asked to provide feedback on the agreed narrative following socialisation within respective groups, discuss the role of CPLG, and agree next steps	**Support** was given for the CCPL Model and Framework, and the direction of travel
8 February 2022	Headache Pathway	Dom Moore, Deputy Chief Pharmacist (UHDB)	CPLG were asked to receive and review the proposed headache pathway. Clinical agreement was sought to publish through JUCD	CPLG were **unable to support** the pathway in its current state - DM was asked to refine the tool based on CPLG feedback and return to CPLG once developed further.
8 February 2022	SEC Ethics Request	William Jones, Chief Operating Officer (DCHS) & Kirsty McMillan, Director of Integration and Direct Services (Derby City Council)	CPLG were asked to consider increasing the risk appetite for delayed discharges.	There was an appetite from CPLG members to look at potential solutions to address the challenges highlighted - CPLG members were happy to **support** a task and finish approach to progress this work.
11 January 2022	Current System Pressures	Ben Pearson, Executive Medical Director (DCHS)	CPLG were asked to consider and support difficult decisions needing to be enacted due to the current system pressures	CPLG **supported** the measures proposed, noting the need to continue to work collaboratively as a system to address these issues. Letter of support sent out to all organisations from CPLG.

APPENDIX 1: 5 Principles: ICS implementation guidance on effective clinical and care professional leadership

Joined Up Care Derbyshire

Principle 1: Ensure that the full range of clinical and professional leaders from diverse backgrounds are integrated into system decision-making at all levels, supporting this with a flow of communications and opportunities for dialogue.

- Fully inclusive multiprofessional clinical and care professional leadership (including general practice, other primary care and community service partners) is central to designing and delivering integrated care and meeting the complex needs of people, rather than just treating their individual conditions.
- This includes allied health professionals, pharmacists, doctors, nurses, social workers/practitioners, psychologists, healthcare scientists, physician associates, midwives, dentists, optometrists, orthoptists and public health professionals, among others.
- Work equally with local government, social care and other partners.

Principle 2: Creating a culture that systematically embraces shared learning, supporting clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities.

- Be systematic in assessment of current arrangements.

Principle 3: Support clinical and care professional leaders throughout the system to be involved and invested in ICS planning and delivery, with appropriate protected time, support and infrastructure to carry out this work

- Ensure clinical and care professional leaders are fully integrated into decision-making on all aspects of ICS functions and governance at every level of the system and create an environment in which distributed leadership can thrive.
- Make tangible improvements to the way clinical and care professionals are integrated into system decision-making and to support them in their system roles and in their development as system leaders (links to principles 4 & 5)

Principle 4: Create a support offer for clinical and care professional leaders at all levels of the system, one which enables them to learn and develop alongside non-clinical leaders (e.g. managers and other non-clinical professionals in local government and the VCSE sector), and provides training and development opportunities that recognise the different kind of leadership skills required when working effectively across organisational and professional boundaries and at the different levels of the system (particularly at place).

Principle 5: Adopt a transparent approach to identifying and recruiting leaders which promotes equity of opportunity and creates a professionally and demographically diverse talent pipeline that reflects the community served and ensures that appointments are based on ability and skillset to perform the intended function.

APPENDIX 1: JUCD Clinical and Care Professional Leadership Framework

**This framework is based on the outputs of the focus group discussions to date and will be further developed to address any gaps. Our development themes in some case cut across multiple principles, as set out in the guidance on 'effective clinical and care professional leadership' (Sept21) ; the table below aims to demonstrates those principles which would predominantly be addressed through the specific areas.*

Joined Up Care Derbyshire

Development Themes - What will be different?	What do we need to do to get there?	Principles supported * 1 2 3 4 5
Model/ Narrative • We have a clear model and narrative that resonates and is applicable at all levels • A cultural shift towards a collective vision/set of priorities which informs decision making	• Use language that is inclusive, relevant and applicable across the system - including Local Authorities and the voluntary sector • Further define what is meant by CPL (multidisciplinary/ multiagency) – build consistent understanding • Consider how the model speaks to/represents operational leaders – socialise and test further	
Distributed leadership • Distributed leadership is key; it is not about having everyone around the CPLG table but how that system leadership group facilitates beyond the group itself • Clinical and professional voices are heard and listened to, enabling dialogue across professions and developments, with the ability to influence wider JUCD priorities • Interdependencies and synergies across the system are recognised, including how we connect, support people and the roles of individual organisations	• Facilitate broader clinical and professional leadership which is connected and representative • Build trusted, open relationships with wider networks; by tapping into existing networks (mapping exercise) and ICS developments (including Place and Provider Collaboratives) • Develop roles as strategic leaders and ambassadors	
Diversity & Inclusivity • Mechanisms are in place to ensure the broadest engagement across system, including Local Authorities and the voluntary sector to have an impact on the wider determinates of health	• Consider how the model links with the ICP through Place and CPLG	
Leadership Roles • Defined clinical and professional roles, responsibilities and representation at the heart of decision making throughout the ICS developments • Ambassadors at Place, with leads connected to CPLG	• Create clarity about the mandate, resources and support for leadership roles across the system • Inspire confidence and establish credibility across organisational and professional boundaries so clinicians are able to work with peers and facilitate conversations to bring the right people together, galvanise support and deal with naysayers • Develop the understanding of what happens where to enhance connectivity and visibility connectivity (e.g. Place and Local Place Alliances) • Influence and support the identification of professionals to sit within various groups, committees and boards, ensuring clear lines of sight between forums and how they link in together • Build on the experience of Primary Care and Place-based development	
Leadership Development • New leaders identified, and nurtured by providing broader system leadership opportunities • Leadership capabilities and behaviours relevant to all leaders are embedded consistently • An environment and culture which gives leaders a voice beyond the constraints of boundaries • Every professional group has some population health understanding	• Develop a common framework of knowledge, skills and behaviours clinical and professional leaders at all levels should enact • Build a strong development offer to support collaborative behaviours and working as system leaders; not just those with a formal system leadership role • Build on what is already in place and works well, e.g. mentorship and coaching - build upwards and outwards to provide an equitable development provision • Recognise different stages of maturity and target developments to address needs • Make stronger links with system OD so a consistent support offer for clinical and care professional leaders at all levels is created which enables learning and development opportunities alongside non-clinical leaders • Promote and utilise initiatives/development opportunities already happening in the system (e.g. Clinical Directors forums to be opened up to other clinical and professional colleagues including primary care and PALM in Place Partnerships) • Promote the personalisation agenda (i.e. person at the centre of decisions) to drive improvements	
Support • Leaders are provided with the necessary time and resource (including aligned management support)	• Consider CPL resourcing (not solely through dedicated funding but also through wraparound support/infrastructure) • Review what we have now, identify gaps and realign to new ways of working • Create learning networks and peer support forums	
Comms & Engagement • Knowledge and understanding of the ICS, its vision and priorities are clearly articulated to give leaders confidence in the new arrangements and the value their contributions adds to the system • Greater visibility, engagement and awareness between clinicians, professionals, managers and the public • Simplified processes with better connectivity between developments taking place at different levels to reduce duplication and complexity	• Develop a communication and engagement strategy/approach to create consistent messages across the system and broaden understanding of the ICS • Actively seek the views of frontline colleagues, for example through regular engagement exercises and annual pulse checks • Build a library of evidence/learning and 'good news stories' of working together • Consider other ways to support clinical and care professionals to have a better understanding of the system	
CPLG Role • Defined distributed leadership model with the group acting as the glue to ensure all aspects brought together and embedded • Recognised, utilised and connected in decision making at all levels as the Strategic Clinical and Professional Leadership Group in the ICS • Informs and is involved in the ICS strategic agenda (inc. ICP Strategy) by providing high quality advice and shared learning/best practice • Acts as the clinical and professional conscience for the system (senate approach) • Develops and oversees Clinical and Professional Leadership by facilitating structures, people and relationships across the system at all levels • System developments are aligned to a consistent framework/principles • Leads and facilitates cultural change • Provides an 'open door' to resolve difficult system problems and has a role in holding partnerships/organisations to account • Responsible for building and connecting networks for anyone with a contribution	• Consider how best to connect other professionals and engage with more isolated groups (e.g. housing, environmental health, social prescribing leads) • Review Clinical & Professional mapping exercise to identify gaps and initiate discussions to consider opportunities for alignment/bringing people/groups together • Inform the development of an evidence based HI strategy (led through Strategic Intent) • Development of a system decision making framework aligned to the Quadruple Aim to provide consistency for decision making all levels; aligned to system priorities, evidence based, and addressing population health needs – recommendations made by CPLG to be accepted by the ICB and wider system • Develop mechanisms so that CPLG is routinely utilised and sighted on key ICS developments with mechanisms to enable feedback by exception where CPLG advice is required over and above/ adding value • Clarity, recognition and utilisation of Senate Advisory Role and how to influence decisions in that capacity • Tap into existing groups/networks and better connect Primary Care • Strengthen the role of CPLG and how it fits within future governance arrangements (including the ICB, ICP, place-based partnerships, Provider collaboratives and Delivery Boards) and any sub-committees; being clear about what we do and what others do and how we all connect • Ensuring broader clinical and professional leadership (beyond CPLG) is represented on all key decision making groups responsible for progressing the design and delivery of integrated care and are connected to CPLG • CPLG act as ambassadors to support consistent implementation of system-wide, best practice approaches (e.g. quality framework developed through SQG)	

APPENDIX 2: CPLG Connectivity to ICS Functions & Decision Making

NOTE THIS IS AT A POINT IN TIME AND MAY BE SUBJECT TO CHANGE

*** The Executive Groups are shown on this diagram for information only at this stage as they are still forming and the CPLG representation may change in light of the developments as necessary.**

Joined Up Care Derbyshire

Derby and Derbyshire Integrated Care Board (see following slides)

Chair: ICB Chair
Lead Exec: ICB CEO
CPLG SLT eps: Avi Bhatia
Accountabilities:

- Statutory organisation leading integration across the NHS. to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place.
- Ensure compliance with legal and statutory duties and obligations including quality, provider selection regime, the People Plan, public involvement and data and digital priorities, emergencies.
- Develop a plan and allocate resource to meet the health and healthcare needs of the population including provision, contracting etc.
- Establish joint working arrangements with partners that embed collaboration as the basis for delivery within the plan.
- Establish governance arrangements to support collective accountability for whole-system delivery and performance.
- Publish an Annual Report setting out how duties were discharged in the previous year.

Decisions:

- Agree and publish a constitution and annual report.
- Agree and publish a plan setting out how it will discharge its duties including the strategies of the HWBBs and strategic objectives and risks.
- Receive assurance from its committees as to the satisfactory discharge of statutory functions and duties or agree remedial actions as appropriate.
- Agree allocation of resources in line with financial regulations and strategic priorities.
- Agree process for assuming delegated responsibilities from NHSEI and for joint working on specialised services.

Health & Wellbeing Boards

Derbyshire County H&W Boar & Derby City H&W Board
Accountabilities:

- Sets the vision and high-level outcomes and priorities for their areas.
- Conducts Joint Strategic Needs Assessments for their areas and for setting the high-level priorities and outcomes in the Joint Health and Wellbeing Strategies.
- Encourages integrated working between health, care, police and other public services in order to improve wellbeing outcomes for the local population.

Decisions:

- Agree priorities and the co-ordination of plans for the integration of health and social care services to improve health and wellbeing of the population and reduce inequalities
- Agree content for contribution to the ICB's Annual Report.

Derby and Derbyshire Integrated Care Partnership

Chair: Rotating City/County HWB and JUCD ICB Chairs
Lead Exec: Strategic Directors of LAs/ICB CEO
CPLG SLT Reps: Avi Bhatia/ Penny Blackwell
Accountabilities:

- Statutory forum where political, clinical, professional and community leaders from across the care and health system come together
- Provide leadership and advise to improve the health and wellbeing of their local population and reduce health inequalities
- Duty to prepare and publish a Joint Strategic Needs Assessment (JSNA) of current and future health and social care needs in relation to the population of the local authority.
- Prepare and publish a Pharmaceutical Needs Assessment (PNA) to assess the need for pharmaceutical services in Derby.
- Prepare and publish a Health and Wellbeing Strategy – a strategy for meeting the needs identified within the JSNA which sets the vision and high-level outcomes and priorities for their areas.
- Duty to encourage integrated working - to advance the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.
- Provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006
- Work collaboratively across local authority area to improve health and wider population outcomes inc. work with Place and Derby Partnership Board

Decisions:

- Support HWB outcomes & priorities and the co-ordination of plans for the integration of health and social care services to improve health and wellbeing of the population and reduce inequalities
- Agree content for contribution to the ICB's Annual Report.
- Drive greater use of resources in prevention (but financial decisions reserved to SFEC)

NHS Executive

Chair: Chair: ICB CEO
CPLG SLT Reps: Chris Weiner/ Amanda Rawlings

The primary purpose of the Joined Up Care Derbyshire (JUCD) NHS Executive is to retain executive level oversight of the NHS delivery, performance (operational, quality, finance) and transformation. The NHS Executive would therefore incorporate the current role undertaken by the regionally led system review meetings (SRMs), providing executive level assurance to inform assurance provided to the Integrated Care Board (ICB).

Remit:

- Overseeing NHS strategic, tactical and operational system planning and delivery
- Overseeing NHS performance improvement and transformation
- Overseeing system performance of the NHS Oversight Framework (Quality of Care, access and outcomes; preventing ill health and reducing inequalities; finance and use of resources; people; leadership and capability; local strategic priorities)
- Managing the system's process of operational control and escalation to the ICB
- Supporting the delivery of assurance against NHS Finance including capital and system efficiency, Quality, People & Culture, Estates and the management of system Risk and Governance
- Ensuring that NHS delivery supports improvements in Derby & Derbyshire populations' Life Expectancy (LE) and Healthy Life Expectancy (HLE) as well as reductions in the Health Inequalities

ICS Executive (NHS and LA)

Chair: Rotating Chief Officers
CPLG Reps: Avi Bhatia (see note above)

The primary purpose of the Joined Up Care Derbyshire (JUCD) System Leadership Team (System SLT) is to be the most senior executive forum for the JUCD health and social care system. The System SLT provides an executive connection to inform the Integrated Care Partnership (ICP). Its primary focus will be collective opportunities and actions to address health inequalities, improve life expectancy and healthy life expectancy, including anchor institution developments, to enable delivery of the Joined Up Care Derbyshire ambitions. Remit:

- ICS development
- Health and social care interface
- Place partnership development and delivery
- Health inequalities: population need and outcomes
- Wider determinants
- Anchor Institutions
- Clinical and professional leadership
- ICP/HWBB strategic intent and development

PROVIDER COLLABORATIVES AT SCALE: System Providers: Provider Collaborative Leadership Board

Chair: Ifti Majid
Lead Exec: TBC
CPLG SLT Reps: Avi Bhatia
Accountabilities:

- The mandate for integrating care
- Provide joint system leadership to transform and address provider quality and efficiency, working together at scale with a shared purpose and effective decision-making arrangements.
- Operational Delivery, Performance & Quality including Silver Escalation
- Plan, deliver and transform services, address unwarranted variation and inequality in access, experience and outcomes across wider populations, improve resilience and ensuring that specialisation and consolidation occur where this will provide better outcomes Increasing efficiency & effectiveness (value)

Decisions:

- Identify and agree opportunities and priorities for collaboration in line with strategic objectives
- Agree on deployment of local assets and resources for service recovery, restoration and transformation
- Agree management of risks and mitigations of each provider partner
- Agree strategic plan collaboration for recommendation to ICB Board

Clinical and Professional Leadership Group (CPLG)

Chair: Dr Avi Bhatia
Objectives:

- To provide advice and assurance to the ICB on matters specifically relating to the NHS and Provider Collaboratives:
- To influence the work of the ICP and Place Partnerships:
- To develop and embed system wide clinical and professional distributed leadership arrangements

Place Partnerships X2 Place Partnership Boards (City and County) and PCNs INTEGRATED PLACE EXECUTIVE

Chair: Dr Penny Blackwell
Lead Exec: Tracy Allen (NHS) and Helen Jones (LA)
CPLG SLT Reps: Penny Blackwell
Accountabilities:

- One Integrated Place Executive (IPE) to co-ordinate and deliver the set of activities that are best done once. These include for example:
- Identifying Place priorities from system strategic plans (e.g., ICB NHS plan, ICP Integrated Care Strategy)
- Planning and overseeing the integration and co-ordination of integrated health and care services.
- Managing relevant whole system transformation programmes.
- Interface with provider collaborative and delivery board output to determine implications for place based provision.
- Hold delegated resources/accountability from ICB (via NHS Lead Provider in first instance).
- Identifying and addressing system / inter-agency barriers to integrated care.

Decisions:

- Agree the operating model for place based working
- Agree on deployment of local assets and resources to support health, social and economic development, including procurement
- Agree integrated and responsive services
- Agree transition plans and support for Glossop

Care Derbyshire: Developing Clinical and

APPENDIX 3: Our agreed Distributed Clinical and Care Professional System Leadership Behaviour Framework

Joined Up Care Derbyshire