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Building strong integrated care systems everywhere

ICS implementation guidance on effective clinical and care professional leadership

NHS England and NHS Improvement may update or supplement this document during 2021/22. Elements of this guidance are subject to change until the legislation passes through Parliament and receives Royal Assent. We also welcome feedback from system and stakeholders to help us continually improve our guidance and learn from implementation. The latest versions of all NHS England and NHS Improvement guidance relating to the development of ICSs can be found at ICS Guidance.

Version 1, 2 September 2021

ICS implementation guidance

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

They exist to achieve four aims:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- enhance **productivity and value for money**
- help the NHS support broader **social and economic development**.

Following several years of locally-led development, and based on the recommendations of NHS England and NHS Improvement, the government has set out plans to put ICSs on a statutory footing.

To support this transition, NHS England and NHS Improvement are publishing guidance and resources, drawing on learning from all over the country.

Our aim is to enable local health and care leaders to build strong and effective ICSs in every part of England.

Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

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About this document

This guidance supports the development of distributed clinical and care professional leadership across integrated care systems (ICSs). It describes 'what good looks like' in this regard, based on an extensive engagement exercise involving over 2,000 clinical and care professional leaders from across the country, led by a multi-professional steering group.

Key points

- The document identifies five core design principles for effective clinical and care professional leadership across ICSs.
- It asks system leaders to develop a local framework for embedding these principles in their ICS arrangements and to ensure that the full range of clinical and care professionals are involved in decision-making at every level of their system.
- To support implementation of this guidance, targeted improvement funding will be allocated to systems in the second half of 2021/2022.

Action required

ICSs, and designate integrated care board (ICB) leaders as they are appointed, should:

- agree an initial local framework and associated development plan for clinical and care professional leadership with partners across the ICS, as part of establishing their arrangements from April 2022
- ensure leaders from all clinical and care professions are involved and invested in the vision, purpose and work of their ICS as it matures.

Other guidance and resources

- ICS design framework
- Thriving places: Guidance on the development of place-based partnerships as part of statutory integrated care systems
- National Quality Board Position Statement on Quality in Integrated Care Systems
- National Quality Board: Shared Commitment to Quality

- Building strong integrated care systems everywhere: guidance on the ICS people function
- Interim guidance on the functions and governance of the integrated care board
- Draft integrated care partnership guidance (due to be published by the Department of Health and Social Care).

Additional resources, including case studies and a summary of the feedback received during engagement on this product, will be available on FutureNHS.

Foreword

Fully inclusive multiprofessional clinical and care professional leadership is clearly central to designing and delivering integrated care and meeting the complex needs of people, rather than just treating their individual conditions. This is why many integrated care systems (ICSs) have made it a priority from the outset.

As we transition to the proposed new statutory arrangements for ICSs, the full range of clinical and care professional leaders, from a diversity of backgrounds, should be involved in decision-making throughout the ICS so they can share and contribute towards a collective ambition for the health and wellbeing of the population.

ICSs should be careful not to lose the depth and breadth of clinical leadership they currently have. They should build on the expertise of existing clinical and care professional networks; for example, Cancer Alliances and networks covering areas like cardiac, renal and respiratory care. This is not to replace existing networks; it is about aligning them within the ICS.

Importantly, this is about involving the full range clinical and care professionals in service design, not just leaders with a specific position or function.

Together they will help ensure the priorities, strategies and plans of the integrated care partnership (ICP) and integrated care board (ICB) fully connect with the needs and aspirations of local communities, service users and carers. They will play a key role in ensuring that care is high quality and that any risks to this are identified and managed effectively.

The COVID-19 pandemic accelerated the shift to system working, empowering clinicians and care professionals to work across traditional organisational boundaries to overcome challenges, protect communities and redesign services when needed. It is important to retain and embed this spirit of innovation as ICSs develop.

In developing this guidance, we listened to clinical and care professional staff who are leading change and delivering frontline services. We wanted to know their hopes and concerns, to design principles that will help them and their colleagues maximise the potential for ICSs to have a profound and lasting impact on health, economic and social outcomes, and to support them to do their jobs effectively and safely.

Clinical and Care Professional Leadership Steering Group

Introduction

This guidance supports the development of distributed clinical and care professional leadership across ICSs. It is part of a set of resources developed by NHS England and NHS Improvement to guide NHS leaders in their preparations to establish statutory ICS arrangements from April 2022.

It does not describe the full breadth of professional leadership arrangements across the ICS or the role of all constituent partners but focuses on how we expect the NHS to contribute to effective clinical and care professional leadership and to work equally with local government, social care and other partners. For non-NHS organisations, including other health and social care providers, local authorities and the VCSE and independent sector, we hope this guidance provides helpful framing on how the NHS will approach clinical and care professional leadership and form a basis for collaborative arrangements across all ICS partners.

It is clinical and care professional leaders, working in partnership with others and with people in local communities, who make improvements happen. They will help realise the ICS mission to improve population health, tackle unequal access to services, experience and outcomes, and enhance productivity, effectiveness and value for money. The evidence is clear that strong clinical and care professional leadership is associated with higher productivity and better organisational performance.

Building on existing arrangements, it aims to help ICSs ensure that 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.

It is the result of an extensive engagement exercise involving over 2,000 clinical and care professionals and partners in local authority, public health, the voluntary, community and social enterprise (VCSE) sector and a wide range of professional membership organisations.

The term **clinical and care professional leadership** is intended to be fully inclusive, reflecting the broad range of professions who need to work together through the ICB, the ICP and across place-based partnerships, provider collaboratives and partners in primary care networks (including general practice and other primary care and community service partners). 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.

Informed by intelligence and insight from people working in systems across the country, our aim was to provide guidance addressing the leadership requirements of developing ICS and their clinical and care workforce, by describing what is possible and what good should look like. The work has been overseen by a multiprofessional steering group (see Annex 1).

The ambitious view of 'what good looks like' in this guidance is intended to stimulate aspiration in systems to strive for continuous improvement and greater clinical and care professional leadership as the ICSs mature. We do not intend to restrict, or prescribe, how systems should go about developing their arrangements for clinical and care professional leadership. Rather, this guidance offers a view of 'what good looks like' and a framework on which to base individual ICS arrangements for clinical and care professional leadership, while retaining the flexiblity that will allow local innovation and adaption.

The document describes:

- two core expectations for ICBs to ensure clinical and care professional leadership is embedded in ICS arrangements from April 2022
- five principles for ICSs to consider when developing arrangements for clinical and care professional leadership and 'what good looks like' in each case, to help systems evaluate current arrangements and identify where more development might be needed.

Elements of this guidance are subject to change until the Health and Care Bill passes through Parliament and receives Royal Assent. All the latest guidance relating to the development of ICSs can be found on the ICS Guidance workspace on FutureNHS here: https://future.nhs.uk/ICSGuidance/grouphome

Core expectations and five principles for integrated care systems

Through our engagement exercise and working with the multiprofessional steering group, we have developed five principles for placing effective clinical and professional leadership at the heart of integrated care systems and two core expectations of all systems to help ensure this is achieved.

Two core expectations for every system

Core expectations

1. Each ICB is expected to agree a local framework and plan for clinical and care professional leadership with ICS partners and ensure this is promoted across the system. The framework should demonstrate how clinical and care professionals will be involved in all aspects of ICS decision-making, building on and aggregating clinical and professional leadership in neighbourhood and place. It should make clear how appropriate and equal professional representation will be achieved and how the leadership community will reflect the diversity of the communities served.

   The local framework should consider how:

   - the five principles in this guidance are reflected in the system's governance and leadership arrangements
   - the ICS will strengthen and further develop its clinical and care professional leadership arrangements for current and future leaders
   - the ICS will support ongoing learning and development opportunities for clinical and care professional leaders
   - the ICS will assess progress in developing effective clinical and care professional leadership, including an element of peer review where appropriate
   - the ICS will undertake regular staff engagement exercises (at least annually) to gauge the views ('pulse checks') of local multi-professional health and care leaders
   - the ICS will ensure that clinical and care professional leaders are empowered to deliver high-quality care and to exercise effective clinical advocacy for individuals and groups who are the most unequal or

	excluded in its communities, this, in turn, will ensure improved health outcomes and reduce unwarranted variation for its local populations.
2.	Individuals in clinical and/or care professional roles on the ICB board, including the nursing director or medical director,* should ensure leaders from all clinical and care professions are involved and invested in the vision, purpose and work of the ICS.

***** These roles (nursing director and medical director) are not exclusive and other clinical and care professionals on the board may be required to perform specific functions.

Five principles for placing effective clinical and professional leadership at the heart of ICSs

In developing their local framework and wider governance arrangements, system leaders are asked to commit that they will:

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.
2. Nurture 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.
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.
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 (eg 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).
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.

What good looks like

The following sections are intended to stimulate thinking for those designing local frameworks and leading transformation for clinical and care professional leadership and that permeates throughout the ICS. The specific responsibilites of particular organisations within the ICS will be for local determination. Systems may want to incoporate other elements and therefore these sections are not exhaustive or restrictive.

Principle 1: Integrating clinical and care professionals in decision-making at every level of the ICS

As ICSs, we will ensure that the full range of clinical and professional leaders from diverse backgrounds ae integrated into system decision-making at all levels, supporting this with a flow of communications and opportunities for dialogue.

What good looks like
Systems integrate a wide multiprofessional range of clinicians and care professionals in their decision-making, planning and strategy-setting forums, possibly illustrated in functions/decision-making mapping. This will show how the governance and decision-making aligns,* including system quality groups. *Including pan-ICS collaboration/governance where this applies.
Clinical and care professionals (regardless of their profession) carrying out a role in the system actively seek the views of frontline colleagues, so that an informed and collective view is used in advice and decision-making.
Systems can illustrate which clinical and care professionals sit on which committees, boards and other groups (including the ICP, place-based partnerships, the board, any committees of the ICB and any workstream and programme boards) showing clear lines of sight between the various forums and how they connect to/feed into one another. This should include clarity about roles and responsibilities for quality across the system. These functions are likely to include (for local determination): • transformational and clinical service redesign: this is multiprofessional clinical and care professional leadership at every level of an ICS

- professional representation and engagement: leaders of specific working or reference groups providing a specific professional viewpoint (eg allied health professionals and healthcare scientist professionals leading corresponding councils or their local or regional professional body networks)
- professional accountability: specific responsibilities, some of which may currently sit within organisations and can only be carried out by a member of a specific profession (eg acute trust medical director and revalidation)
- current CCG functions and statutory responsibilities that will be conferred on ICBs
- current statutory and other functions that sit with NHS England and NHS Improvement regionally that may be devolved to ICBs and potential links and joint functions with local authorities.

The system has purposefully considered and identified the full breadth of care professionals and is confident that all care professionals, including social care, are integrated and involved in decision-making. System partners invest in building relationships between NHS and social care leaders so that the right individuals are involved at the outset and there is a balanced view across health and care. This will include a wide range of professionals, including social workers, domiciliary care workers, mental health professionals and those representing the care home sector, among others.

Where decisions are made (eg regarding priorities for service redesign or changes to the way that care and treatment is organised and delivered) clinical and care professionals have been directly involved in them.

Following the principle of subsidiarity, decisions should be made as close to the patient as possible. This will be at neighbourhood where possible and at place and system where appropriate.

Decisions and intelligence sharing across the ICS is timely and transparent; where concerns and risks are identified, they are acted on promptly.

The ICS involves the full range of health and care professionals from diverse backgrounds when setting priorities in systems and places. This will include the full range of clinical and care professionals, managerial and operational leaders, as well as leaders from the VCSE sector, citizens, patients and carers.

The system has a communications and engagement plan in place that enables clinicians and care professionals to see what is happening across the system, build connections, celebrate progress, and share practice and opportunities for improvement (eg learning from incidents).

The plan covers how two-way communication will be achieved so that clinical and care professionals across the wider community (and not just those in decision-making roles) can contribute their views and influence decision-making.

There is a mechanism to 'test', perhaps using techniques such as appreciative enquiry, whether clinical and care professionals feel their voices have been heard, which could be validated via a staff survey for this group.

The system has mechanisms to ensure that professionals can uphold the rights of local citizens, including when compulsory treatment or admission is considered, where people are at risk of or are experiencing abuse or neglect or where they may be deprived of their liberty. Overall there is a mechanism to check how clinicians have made a positive difference.

The ICB is responsible for ensuring that the fundamental standards of quality are delivered and that there is continual quality improvement in NHS services across the ICS. This requires close collaborative working with system partners (including providers, people using services, NHS England and NHS Improvement regional teams, regulators and wider partners), shared quality improvement priorities and shared ownership of risks.

ICBs should ensure their board has clear governance and escalation processes for quality (including safety) in place, and actively monitors and manages system quality risks, in a way that enables continual learning and improvement.

The ICB has processes in place to ensure that items going to the board have been co-produced and/or informed by appropriate opinion from clinical and care professionals and by the people and communities they serve.

Principle 2: Creating a culture of shared learning, collaboration and innovation, working alongside patients and local communities

As ICSs, we will nurture 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.

What good looks like
System partners have agreed methods for bringing different groups of leaders together to drive transformational change and delivery. System leaders work collaboratively with clinical and care professionals, encouraging curiosity and flexibility to maximise innovative thinking. System leaders consider how they can effectively gather a ‘consensus’ view from relevant professional groups (eg primary care) to inform engagement, achieving a ‘single voice’ where helpful.
The system has a means of mapping and aggregating the community assets of its local partnerships and enables clinical and care professionals to make connections, working with others outside its immediate circle. This should include the independent sector and professional membership organisations (including community groups, VCSE organisations, local charities and support groups) as well as user groups and citizens and those who have lived experience (eg learning disability, autism, mental health). The system draws on the wide range of expertise, knowledge and experience of professional membership bodies/organisations when redesigning services (eg workforce considerations).
To encourage a culture of shared learning, the system will have considered and implemented opportunities for clinical and care professionals to lead and/or participate in forums (such as multiprofessional events, virtually and face-to-face) where good practice and lessons learned are shared in a manner that enables clinical and care professionals to feel safe and supported.
Systems have mechanisms to review the evidence on the impact of its transformation programmes and supports clinical and care professionals to drive the spread and adoption of innovation across the ICS, through measurement of impact and horizon scanning (eg learning networks).
In developing local strategies, system partners give thought to how the workforce across the ICS can be involved/engaged and feel a sense of responsibility for delivery of its ambitions. This might cover: • communicating the vision and strategy of the ICS, including at induction

- targeting specific groups of clinicians and care professionals, focusing on their particular areas of work and how that connects to the ambitions of the ICS. People need to understand this connection before they can start to feel a sense of being 'part' of a system
- encouraging clinicians and care professionals so they feel energised and motivated in the work they are doing and can see how it contributes to the overall success of the ICS strategy.

The ICS develops methods of measuring how well its collaborative arrangements are working. This might involve:

- a regular stocktake: identifying new ideas/ways of working that have been implemented and checking to see if they are working or not
- stopping/changing what is not working: capturing the learning from this, then putting something new in place
- an assessment of how successfully the ICS is working with people and communities
- putting in place an ongoing programme of checks and balances: identifying any development needs which may arise and the corresponding budget/resources to support these.

Principle 3: Ensuring clinical and care professional leaders have appropriate resources to carry out their system role(s)

As ICSs, we will 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.

What good looks like

Clinicians and care professionals are given sufficient dedicated, scheduled protected time and/or back-fill during the working week to undertake system roles, and the time allocated for these roles is appropriate for the work required.

Particularly for formal system roles, and where appropriate, this may require paid secondments, fixed-term appointments, back-fill and so on.

Where appropriate, employing organisations may need to agree to release their clinical and care professional leaders, enabling them to participate in system work

(eg clinical networks, specific transformational/improvement programmes and projects).
The ‘ask’ of clinicians and care professionals in system roles is clearly defined so that time spent on the task is as productive and rewarding as possible. This ‘ask’ is set out clearly in job descriptions/person specifications, and is clear about whether a role is: • transformational/clinical service redesign • professional representation • professional accountability • statutory role/responsibility currently held by CCGs • statutory role/responsibility that may be delegated from NHS England and NHS Improvement to ICBs and potential links and joint functions with local authorities.
Clinicians and care professionals have appropriate access to administrative support when undertaking system leadership roles and responsibilities. System partners will make it clear how this can be accessed (at every level of the system) and make a commitment on the appropriate administrative time being available and where to find it.
Clinicians and care professionals have appropriate access to other forms of support when undertaking system roles (including project and programme management, data analysis, improvement methodologies, change management and finance expertise) and individuals supporting them have sufficient time to do so.
Clinicians and care professionals have access to relevant shared data and analytics, to health economists and research academics and to training, if required, to enable them to use data most effectively.

Principle 4: Providing dedicated leadership development for all clinical and care professional leaders

As ICSs, we will 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 (eg 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).

What good looks like
System partners agree defined budgets for the development of clinicians and care professionals working in system leadership roles.
Systems have a clearly defined ‘systems leadership’ support offer, one which addresses the key behaviours and skills required to support effective system working and enables, in particular, those working at ‘place’ to deliver population health-focused care, including: • ability to work successfully beyond organisational boundaries to bring about change for the benefit of the population • ability to apply population health techniques and methodologies to drive service transformation and proactive integrated care models, using linked data and risk stratification to identify at-risk cohorts • acting with integrity in an open, honest and inclusive manner • working with all partners to create a shared vision in which there is space and opportunity to understand all perspectives and contributions • strong relationship building and communication skills, working with partners to develop a shared vision, joint priorities and plans • a readiness to take ownership of complex problems that could be perceived as being the responsibility of others in the system.
The system has taken learning from its systems leadership programmes; those run by formal training providers (eg the NHS England and NHS Improvement Leadership Academy) and from evaluation of other national programmes (such as a multiprofessional leadership programme) to inform the core competencies for its clinical and care professional leadership roles, including them in job descriptions and using them recruitment. Assessment against these competencies will be a key feature of appraisal and personal development processes.
The support builds on the place-based systems leadership programmes which NHS England and NHS Improvement supported with investment in 2018-2020, meaning that ICSs will already have a platform from which to build. m

Systems leadership development is additional to the continued need for professional-specific training.
Staff groups at all levels in the ICS should have equitable opportunity to access support offers. The ICS might consider its processes/mechanisms for advertising and promoting system leadership development opportunities to ensure that the wide range of clinical and care professions not only to know about what is on offer, but can take up the various opportunities.
Clinical and care professionals are supported to take time away from the day job to participate in system learning opportunities, including coaching, mentoring, peer support networks and actions learning sets.

Principle 5: Identifying, recruiting and creating a pipeline of clinical and care professional leaders

As ICSs, we will adopt a transparent approach to identifying and recruiting leaders which promotes equity of opportunity and creates a professionally and demographically diverse talent pipeline which reflects the community served and ensures that appointments are based on ability and skillset to perform the intended function.

What good looks like
System partners have mapped current clinical and care professional leadership and make this information available to ensure that other people working in the system know who is leading on what, and how to contact them.

The ICS taps into the knowledge and experience of all partners to find out where the future system leaders are, so they can be supported and developed into system roles; drawing on their 'existing talent' knowledge.

ICBs work with their workforce leads and NHS Leadership Academy, particularly the regional talent teams, to shape diverse talent pools and develop their talent management approaches, drawing on the latest theory and practice.

System partners collectively use workforce planning intelligence to horizon scan for current and future workforce pressures/shortages/skill mix, and plans/mitigates effectively.

Systems will have clear, transparent and inclusive processes for advertising, recruiting and promoting to all roles across the ICS, including system clinical and care professional roles, purposefully encouraging new talent to step forward.

System partners work to ensure consistent recruitment and promotion practices that address biases and improve diversity, and set clear accountability for equality, diversity and inclusion (see Model Employer).

ICSs take steps to ensure their clinical and care professional leaders reflect the populations they are working with, as well as the diverse range of professions which meet the needs of local communities. Including:

- demonstrating how the system is building a diverse and inclusive leadership community in line with the NHS England and NHS Improvement Phase 3 recommendations by publishing an action plan in 2022/23 showing how, over the next five years, the NHS ICS body board and senior staffing will, in percentage terms, match the ethnic minority composition of its overall workforce, or its local community, whichever is the higher
- operating inclusive (race, gender and disability) recruitment processes for clinical and care professional leaders, including diverse interview panels and offering flexible working (eg to consider caring responsibilities) and home working where appropriate
- demonstrating ways in which clinical and care professionals have facilitated reasonable adjustments and inclusion in their approach to delivery and transformation of care.

Supporting implementation of the guidance

Putting ICSs on a statutory footing provides a significant opportunity to 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.

We heard throughout our engagement that national organisations should not mandate how ICSs go about taking account of the principles set out in this document; they should be left to locally determine the right approach. That said, we also heard that now is the perfect time to reflect and be ambitious on this agenda.

We encourage systems to be systematic in their assessment of current arrangements, considering how they could meet the core requirements set out in above and how they could achieve 'what good looks like'. Many systems will go further still.

NHS England and NHS Improvement will support systems to implement this guidance where this is helpful, working in partnership with the NHS Leadership Academy and representatives of local government, social care, public health and other professional partners, where it makes sense to do so. During engagement, leaders told us what they felt was important when it came to delivering support:

- a range of support, including systems leadership development and general management training
- approaches focused on how leaders can be developed in different and innovative ways, moving away from more traditional models
- coaching and mentoring for those emerging, or maturing, into system roles to support talent management
- supportive programmes of organisational development to accelerate new ways of working
- recognition of the different skillsets required for system working
- inclusive access to support for every clinical and care professional group.

We understand how important it is to scale up the number of clinical and care professional leaders with the skills needed to be confident and successful in the system environment. To support implementation of this guidance, additional improvement funding will be allocated to systems in the second half of 2021/22.

Allocations will be informed by system development plans and agreed between system leaders and regional teams.

Funding should be directed where system leaders consider it will add most value, which could include (not an exhaustive list):

- investment in senior capacity to develop the system's strategy and model for clinical and care professional leadership
- design/delivery costs for a systems leadership development offer; enabling additional cohorts of clinical and care professionals to access place-based system leadership development
- establishment of a clinical and care professional network manager, supporting the ICS SROs to design, develop and deliver the ICS model (potentially at regional/subregional level).

Implementation plans should build on the work ICSs have already done through the place-based leadership programmes NHS England and NHS Improvement have funded over the last two years. This national programme of funding has been evaluated. The learning from that will be available on FutureNHS.

Further details on the full range of support available from NHS England and NHS Improvement will be provided on FutureNHS.

Annex 1: Membership of the Clinical and Care Professional Leadership Steering Group

Name	Job title
Professor Neil Anderson	Consultant Clinical Biochemist, and Clinical Director, Clinical Diagnostic Services, University Hospitals Coventry & Warwickshire NHS Trust
Hassan Argomandkhah	Senior Clinical Pharmacist; Prescribing Lead, Primary Care, Knowsley; Chair of Pharmacy Local Professional Network (NHS England and NHS Improvement, Merseyside)
Professor Des Breen	Medical Director, South Yorkshire & Bassetlaw ICS; National Clinical Advisor, System Transformation Team, NHS England and NHS Improvement
Glen Burley	CEO, South Warwickshire NHS Foundation Trust, Wye Valley NHS Trust & George Eliot Hospital NHS Trust
Dr Charlotte Canniff	Clinical Chair of Surrey Heartlands Clinical Commissioning Group; Clinical Leader Surrey Heartlands Integrated Care System; Co-Chair of Surrey Heartlands Health and Care Professional Executive
Richard Cattell	Deputy Chief Pharmaceutical Officer, NHS England and NHS Improvement
Caroline Chipperfield	Director, Leadership Development & Delivery, People Directorate, NHS England and NHS Improvement
Dr Shera Chok	GP, Tower Hamlets; Co-founder and Chair, The Shuri Network; Deputy Chief Medical Officer, NHS Digital; National Clinical Advisor, System Transformation Team, NHS England and NHS Improvement
Dr Kiren Collinson	GP, Oxford; Clinical Chair, Oxfordshire CCG; Interim Deputy Medical Director, Primary Care, NHS England and NHS Improvement
Jo Harding	Executive Director, Nursing & Quality, NHS Leeds CCG
Dr Graham Jackson	Chair, NHS Clinical Commissioners; Senior Clinical Advisor, NHS Confederation
Dr Sakthi Karunanthi	Director of Public Health, Lancashire County Council
Margaret Kitching	Regional Chief Nurse, NHS England and NHS Improvement (North)
Angela Knight Jackson	Head of Nursing Development Programmes, National Nursing Directorate (Professional & System Leadership), NHS England and NHS Improvement
Dr Ursula Montgomery	GP and Senior Clinical Advisor, NHS England and NHS Improvement

Lou Patten	Director, ICS Network, NHS Confederation; CEO NHS Clinical Commissioners
Vanessa Read	Director of Quality & Nursing, Dorset CCG
Gina Sargeant	Head of Therapies & Professional Lead, AHP RUH, CCIO & CSO, Royal United Hospitals Bath NHS Foundation Trust
Dr Christopher Scrase	Macmillan Clinical Lead for Cancer, Suffolk & North East Essex ICS; Macmillan Consultant Clinical Oncologist, East Suffolk & North Essex NHS Foundation Trust; NHS England and NHS Improvement Radiotherapy CRG Clinical Member & Quality Improvement Lead
Dr Jessica Sokolov	Medical Director, System Improvement & Professional Standards, NHS England and NHS Improvement (Midlands)
Deborah Sturdy	Chief Nurse, Adult Social Care, DHSC
Dr James Thomas	Clinical Chair, Bradford & District CCG; Chair, Clinical Forum, West Yorkshire & Harrogate Health & Care Partnership; Joint SRO, Improving Population Health Programme, West Yorkshire & Harrogate HCP

For more information on Integrated Care Systems visit:
www.england.nhs.uk/integratedcare/

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