Report of the Director of Collaboration, NHS Airedale, Wharfedale & Craven, Bradford City and Bradford District CCGs, to the meeting of the Health & Well Being Board to be held on 29th July 2014.

B

Subject:

Integration and Change Board and Bradford Health and Care Commissioners
(collaboration between Bradford and Airedale CCGs, Local Authority and NHS England, West Yorkshire Area Team)

Summary statement:

The Integration and Change Board provides system wide leadership and accountability for the delivery of integration within the Bradford district health and care economy*. In line with the established governance arrangements, and the requirements of the Health and Wellbeing Board terms of reference, this report updates Health and Wellbeing Board on the key messages emerging from, and the main work areas being progressed through, the Integration and Change Board through receipt of the minutes of the meetings held in April and May 2014.

In November 2013 and March 2014 a report was provided for the Health and Wellbeing Board on key work streams overseen by Bradford Health and Care Commissioners and this report is a further update in line with the required reporting arrangements.

As part of the required governance arrangements, the annual review of Bradford Health and Care Commissioner Terms of Reference took place at the June meeting, and these are required to be endorsed by the Health and Wellbeing Board.

*This include Bradford Metropolitan District Council & Craven

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Portfolio:
Adult Services and Health

Overview & Scrutiny Area:
Health and Social Care

1. SUMMARY

The Integration and Change Board provides system wide leadership and accountability for the delivery of integration within the Bradford district health and care economy*. In line with the established governance arrangements, and the requirements of the Health and Wellbeing Board terms of reference, this report updates Health and Wellbeing Board on the key messages emerging from, and the main work areas being progressed through, the Integration and Change Board through receipt of the minutes of the meetings held in April and May 2014.

In May 2013 the Health and Well Being Board received a report on the role of collaborative commissioning arrangements (now known as Bradford Health and Care Commissioners) including key work streams. As part of that report in line with its terms of reference, it was confirmed that Bradford Health and Care Commissioners, which meets 3 times per year, will report into the Health and Well Being Board as part of the groups and partnerships across the district to support the delivery of the Health and Well Being Strategy. In November 2013 and March 2014 a report was provided for the Health and Wellbeing Board on key work streams overseen by Bradford Health and Care Commissioners and this report is a further update in line with the required reporting arrangements.

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2. BACKGROUND

2.1 At the May Health and Wellbeing Board meeting members received an update on the key messages and priorities being progressed by the Integration and Change Board (ICB) and were in receipt of the minutes from February and March 2014 meetings in line with the required governance arrangements.

2.2 In line with established reporting arrangements at Health and Wellbeing Board meetings in November 2013 and March 2014 updates were provided on work-streams which are being overseen by Bradford Health and Care Commissioners.

3. REPORT ISSUES

3.1 Within Bradford Health and Care Commissioners work has continued on overseeing and developing joint commissioning priorities which remain at the forefront of its agenda, along with the development of an annual work programme which supports the delivery of joint commissioning.

3.2 Particular progress is being made in joint commissioning across a number of areas including;

- Continuing health care - which is progressing to bring the two teams across health and social care together and should be in place by the end of the year.
- Carers Hub – a process of joint procurement is underway across the Local Authority and CCGs to deliver better value for money and better outcomes for recipients of services
- Domestic violence support services – a decision to jointly procure domestic violence support services across the Local Authority and Clinical Commissioning Groups has been made given the level of overlap in terms of both activities and outcomes, with a view to services commencing April 2015

3.3 Additionally the Local Authority and CCGs are also working together to review and finalise the needs/requirements of 'infrastructure' support for Third Sector organisations within the District. This is due to be completed by September 2014, followed by a procurement process, with an implementation date of 1st April 2015.

3.4 Specific work is taking place to instigate joint commissioning for Learning Disabilities and further exploratory work is underway on the scope of joint commissioning opportunities and arrangements within Mental Health and Children's Services (which is being supported by the NHS Improving Quality, Transformational Change Capability Building Programme). This work will be progressed outside of Bradford Health and Care Commissioners and commissioning leads will take this work through respective decision making mechanisms in the Council and CCGs to achieve formal sign up.

3.5 NHS England, West Yorkshire Area Team are engaged in Bradford Health and Care Commissioners and have shared NHS England operational and strategic plans for primary care, dental and public health direct commissioning. This allowed discussions to take place on;

a) Unscheduled (urgent) dental care procurement and the capacity that the new service needs to be able to deliver and respond to locally
b) Resources that currently sits with the 3 CCGs' general practices and the assumption within the 5 year health and care strategy that this remains within the District's strategic planning resource pot, accepting there is a piece of work to do on the equitable spread of those resources across the District.

3.6 Bradford Health and Care Commissioners following its first cycle of annual meetings reviewed its terms of reference and rotated the arrangements for Chair and Deputy Chair, as required. As part of a review of working arrangements it agreed to continue to meet 3 times per year, revised membership of the CCGs, confirmed its sub group arrangements and agreed to review it terms of reference annually. The revised terms of reference are attached at Appendix 1 and require endorsement by the Health and Wellbeing Board.

3.7 Through its monthly meetings the Integration and Change Board (ICB) continues to work together to progress the development of the 5 year strategy for Bradford, Airedale, Wharfedale and Craven (now known as the Forward View) as well as monitor the progress on programme implementation across the integration and change portfolio; which includes, integrated care for adults, urgent care, children' services transformation and integration and adult services transformation.

3.8 ICB has overseen the development of the 5 year health and care strategy (Forward View) and through nominated planning leads from each organisation they have been working through developing a collective submission which aligns with provider hospital trusts plans which have been submitted within the same timeframe. The 5 year health and care strategy (Forward View) as submitted to NHS England on 20th June 2014, is on the agenda of the Board today.

3.9 To reflect the scope of the 5 year health and care strategy (Forward View) ICB has considered the current programme arrangements across the integration and change portfolio and is looking to include additional areas including planned care, primary care and community services, self care, prevent and early intervention and as well as extending the scope of the existing system and infrastructure programme. Work is also underway to refine and consolidate the corporate risk register in light of the 5 year strategy (Forward View). This will allow ICB to monitor the risk register and update it to reflect any emerging strategic risks from the 5 year health and care strategy.

3.10 Additional members have joined ICB to support it working as a collective Board for the District; including the Chief Executive of YOR Local Medical Committee as a representative of primary care providers, and the Director of Finance from Yorkshire Ambulance Service.

3.11 The Integration and Change Board continues to work together on the detail of Better Care Fund plan which was submitted on 4th April 2014 (albeit at the a high level), and which will be re-submitted in September 2014. Work has been commissioned to develop options for hosting the pooled fund of £38m and the supporting governance arrangements. A task and finish group has been established to report into ICB on how Better Care Fund resource is best used to support the required transformation priorities (supported by an evaluation framework to determine costs, benefits and risks). In addition Directors of Finance are supporting this work through working together to adopt an `open book' approach for 2014/15 and 2015/16 across the system to create absolute transparency about assumptions on income, expenditure and cost savings schemes.

4. FINANCIAL & RESOURCE APPRAISAL

There are no financial issues arising from this report.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

Not applicable.

6. LEGAL APPRAISAL

No legal issues.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

7.1.1 Health and Wellbeing Boards have responsibility to improve the health of their

population and to reduce health inequalities. They are responsible for assessing the needs of the population through production of a Joint Strategic Needs Assessment (JSNA) and for setting out how those needs will be addressed in a Joint Health and Wellbeing Strategy. In Bradford this is further enhanced through the development of and implementation of a Health Inequalities Action Plan.

7.1.2 Bradford Health and Care Commissioners and the Integration and Change Board as part of its governance arrangements reports into the Health and Well Being Board as part of the groups and partnerships across the district to support the delivery of the Health and Well Being Strategy.

7.2 SUSTAINABILITY IMPLICATIONS

Not applicable.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

Not applicable.

7.4 COMMUNITY SAFETY IMPLICATIONS

Not applicable.

7.5 HUMAN RIGHTS ACT

Not applicable.

7.6 TRADE UNION

Not applicable.

7.7 WARD IMPLICATIONS

There are no ward implications as all wards are covered by the three CCGs and by BMDC.

8. NOT FOR PUBLICATION DOCUMENTS

None

9. RECOMMENDATIONS

9.1 That the Board endorses the Bradford Health and Care Commissioners Terms of Reference
9.2 That the Board receives the minutes of the Integration and Change Board (April and May 2014)

10. APPENDICES

Appendix 1 - Bradford Health and Care Commissioners, Terms of Reference
Appendix 2 - Integration and Change Board - Minutes, April 2014

Appendix 3 - Integration and Change Board - Minutes, May 2014

11. BACKGROUND DOCUMENTS

None

Airedale, Wharfedale and Craven
Bradford Districts
Bradford City
CCGs working together
NHS

NHS England

City of Bradford MDC
www.bradford.gov.uk

TERMS OF REFERENCE
Bradford Health and Care Commissioners

1) Remit

1.1 The establishment of a collaborative commissioners arrangement involving the Bradford & Airedale CCGs and other commissioners including the Local Authority is intended to create a collaborative mechanism that will provide a formal platform for Health and Social Care to review evidence and to debate and consider strategic commissioning priorities and their delivery across the local health and social care economy. This arrangement will also allow collaboration with other commissioners including the NHS England, as required.

2) Purpose

2.1 The purpose of this collaborative mechanism is to enable high level joined up planning and prioritisation of commissioning plans to take place between each of the three Clinical Commissioning Groups (CCG's), and the relevant commissioning leads within the Local Authority (LA), and NHS England where appropriate. This collaborative forum, known as Bradford Health and Care Commissioners, will where appropriate, make recommendations to each commissioner through their formal decision making committee arrangements in line with their delegated powers of decision making. The collaborative itself will not operate as a committee of any commissioning organisation

3) Duties and Powers

3.1 Business

3.1.1 To collaboratively consider the delivery of priorities and strategic commissioning plans that align with and drive the objectives of the Health and Wellbeing Board

3.1.2 To provide a mechanism to enable decisions to be guided by information from different sources and views from a range of perspectives

3.1.3 To jointly influence the design and direction of strategic commissioning plans to support integration and to achieve the objectives of the Health and Wellbeing Plan

3.1.3 To jointly assess any potential risks of proposed service changes

3.1.5 To jointly measure direct impact upon service users and local communities of any significant change to pathways, service models, or decommissioning

3.1.6 To collectively understand and prepare for variations in demand and supply and their impact on local market conditions, and respond in a coordinated way

3.1.7 To collectively understand and prepare for changes in systems and structures and in patterns in demand for care associated with legislative, economic and demographic change.

4) Accountability and Reporting Arrangement

4.1 Bradford Health and Care Commissioners will provide assurance to constituent CCG Clinical Boards, Health and Wellbeing Board and Children's Trust Board through reporting key outcomes.

4.2 These terms of reference and any subsequent revisions will be agreed mutually through CCG Boards and the Health and Wellbeing Board and Children's Trust Board.

4.3 The arrangements for the Chair will rotate between commissioners (CCGs and Local Authority) with the Director of Public Health undertaking this role for the second annual cycle of meetings and this will be reviewed again at end of 2014 after the second annual cycle of meetings. The Clinical Chair from Bradford City CCG will act as Deputy Chair in the event the Chair is not available.

5) Membership

5.1 Bradford Health and Care Commissioners is designed to be a formal commissioners collaborative mechanism that can drive strategic integrated commissioning across health and social care in Bradford District. It will therefore comprise the following membership:

<u>Local Authority</u>

- LA Adult & Community Services – Strategic Director, Assistant Director, Assistant Director of Commissioning
- LA Children, Young People and Families - Strategic Director, Senior Manager, Strategic Commissioning
- LA Public Health – Director of Public Health

<u>Bradford and Airedale CCGs</u>

- Bradford Districts CCG – Clinical Chair & Chief Officer, Director of Strategy
- Bradford City CCG – Clinical Chair and Chief Officer, Director of Strategy
- Airedale, Wharfedale and Craven CCG – Clinical Chief Officer and Chief Operating Officer,

- Bradford and Airedale CCGs - Director of Collaboration
- Bradford and Airedale CCGs - CCG Collaboration Senior Lead

Other Commissioners

- NHS England – West Yorkshire Area Team, Head of Primary Care

5.2 In addition Bradford Health and Care Commissioners will invite other partners and staff to attend for specific agenda items:

- Local Authority Officer representatives
- NHS England - West Yorkshire Area team
- Representatives of local service providers
- Representatives of other CCGs

5.3 In order to support the importance of continuity in engagement and strategic collaboration, members of Bradford Health and Care Commissioners may nominate deputies to attend on their behalf. These should be named individuals to ensure consistency.

6) Conflict of interest

6.1 It is recognised that all members of Bradford Health and Care Commissioners will, on occasions, have conflicts of interest. Robust processes exist in each organisation to mitigate against these in the interests of the public, the organisations and the individuals involved.

6.2 Members and officers are required to work within the declaration of interests processes within their respective organisations when they join Bradford Health and Care Commissioners and a register will be maintained in each organisation and kept up to date.

7) Quorum

7.1 No business shall be transacted unless each of the CCGs and the Local Authority is represented through Clinical Board or Executive Group Member presence (1 per CCG) and Local Authority (minimum 2 senior officers).

8) Frequency of meetings

8.1 Bradford Health and Care Commissioners shall meet at least 3 times per year. The schedule of meetings for 2014 is as follows:

Friday 21st February 2014 With Local Authority	13.30 – 16.00	Room 1.1, Level 1 Douglas Mill
Friday 20th June 2014 With Local Authority	13.30 – 16.00	Room 1.1, Level 1 Douglas Mill

Friday 17th October 2014 With Local Authority	13.30 – 16.00	Room 1.1, Level 1 Douglas Mill

8.2 Bradford Health and Care Commissioners will deliver priority areas as set by the Joint Health and Wellbeing Strategy and the Bradford 5 year Health and Care Strategy which would derive significant benefits from a coordinated approach. The Investment and Commissioning Group as a joint operational group will support delivery of agreed work-streams.

8.3 Agenda setting will take place between CCGs, the Local Authority and NHS England West Yorkshire Area Team in line with the commissioning cycle. A forward planner will be developed and considered at each meeting in terms of managing future agendas. A call for agenda items will take place one month prior to each meeting. The planning for business items to feature as part of the agenda would need to coincide with the main elements of the commissioning cycle as it unfolds across the year.

8.4 A review of the frequency and effectiveness of meetings will be undertaken as required in line with governance arrangements.

8.5 Administrative support for the Bradford Health and Care Commissioners shall be provided from within the CCGs as part of their collaborative operating model. This will include preparation and sending out of agendas and minutes of the meeting.

9) Review of Terms of Reference

9.1 Bradford Health and Care Commissioners shall review its Terms of Reference at least annually. The next review will take place in June 2015.

Version 7 Revised June 2014

Health & Social Care Partners in Bradford, Airedale, Wharfedale & Craven

Action notes of the Integration and Change Board (ICB)
held on Friday 25 April 2014
9.00-10.40 at Douglas Mill

Present:	Tony Reeves (Chair)	Chief Executive, BMDC
	Bryan Millar	Chief Executive, BTHFT
	Bridget Fletcher	Chief Executive, AFT
	Helen Hirst	Chief Officer, Bradford CCGs
	Damien Kay	CCG Collaboration Senior Lead, Bradford & Airedale CCGs
	Janice Simpson	Strategic Director, Adult & Community Services, BDMC
	Anita Parkin	Joint Director of Public Health, BMDC
	Phil Pue	Chief Clinical Officer, AWC CCG
	Ann Wagner	Director of Strategy & Business Development, AFT
	Liz Romaniak	(Interim) Director of Finance, BDCT
	Juliette Greenwood	Chief Nurse, BTHFT
	Simon Large	Chief Executive, BDCT
	Akram Khan	Clinical Chair, Bradford City CCG
	Andy Withers	Clinical Chair, Bradford Districts CCG
	Sue Cannon	Director of Nursing and Quality, WYAT NHSE
	Michael Jameson	Strategic Director of Children's Services, BMDC
In attendance:	Cath Doman	Head of Service Improvement, Bradford CCGs
	Susan Bajwa	Personal Assistant, Bradford CCGs
Apologies:	Nancy O'Neill	Director of Collaboration, Bradford & Airedale CCGs
	Sue Pitkethly	Chief Operating Officer, AWC CCG

14/15 MINUTES OF THE MEETING HELD ON 21 MARCH 2014 AND MATTERS ARISING

The minutes were agreed as an accurate record of the meeting.

All other actions are completed or part of the agenda for discussion.

2. MATTERS ARISING

a) HWB NHS Provider Trust Membership

With regard to the suggestion of all 3 providers attending HWB, Tony advised that the HWB were not happy with the proposals of rotating on a meeting by meeting basis. HWB want the team to come together and move forward and their suggestion was rotation on an annual basis to allow this to take place.

b) Primary Care Representation at ICB

Andy Withers had spoken to Dougy Moederle-Lumb, Chief Executive of the YOR LMC, and informed him of the discussion which had taken place at last month's meeting regarding corporacy and general practice representation at ICB. He understood there was no single voice from general practice but was quite happy to try to bring those views

round the ICB table and then take the corporate view and represent those within the wider GP community. Dougy was happy with the description of ICB, so we therefore had a willing volunteer. It was acknowledged that it was important to have GP representation at the ICB but they needed to agree to this and mandate this as their preferred model. It was accepted in the future this may change if primary care become more organised in how they work together.

c) System Mentor Role

The System Mentor role was discussed at the HWB development day and the view was that it would be good to have such a role and it was suggested that Mike Farrar would be an appropriate person to undertake this. HWB's view at the development session was that it would be a useful role and they would be happy for Mike Farrar to carry this out.

Damien Kay had discussed with Nancy O'Neill the relationship with ICB and also HWB and it was felt that the relationship with both Boards needed to be right and at what point did he come back and challenge ICB and at what point did he challenge HWB. This therefore needed to be picked up in discussion with Mike Farrar as part of securing this role.

It was proposed that HWB commission Mike Farrar for 5 sessions per year, 3 for HWB and 2 six monthly sessions for ICB, with the cost shared between organisations. This arrangement will be reviewed after a year given HWB and ICB will be in an implementation phase a year on and the mentor requirements may look different. An appropriate share of the cost will be worked out at HWB level and then shared with everyone.

ACTION - Progress Chief Exec of YOR LMC undertaking primary care representation as member of ICB on the basis there is a mandate from primary care and this is their preferred model.

ACTION - Collectively commission Mike Farrar through HWB as system mentor – 5 sessions per year (3 sessions @ HWB and 6 monthly ICB).

3 Better care fund – final submission

The second, and final, version had now been submitted through HWB for approval. There has been another regional peer review by the Directors of Adult Social Services with support from the Local Area Team, feedback was awaited. Tony Reeves however had seen it this week and they had done a 9 box risk matrix and we were in the mainly in the middle box however they initially gave Bradford a red due to some analysis on spend per head of population as our position was worse than others – this was seen as a technical error and adjusted. We are now in the same box as everyone else with only top notch being Wakefield as it was more joined up and transformative so it was suggested we should have a look at the learning from that. Janice Simpson added that we needed to progress and agree who was going to hold the pooled fund, who would get the money and how it would be monitored so the Investment and Commissioning Group will look at that on behalf of ICB. Damien Kay advised that the CCG Chief Finance Officers had suggested that we commission the West Yorkshire Audit Consortium to undertake an options appraisal including the pro's and con's of who would hold the budget, look at the governance arrangements and the monitoring which would fall out of that.

Phil Pue asked about the process and timetable for confirming priorities as their TIG were looking at areas where they to make a transformational change but was informed that this had not been agreed yet. Janice agreed to bring a paper to the next meeting covering the main priorities, the approach we are adopting in order that it could be signed off collectively.

Helen Hirst felt that the ICB had quite a critical role in determining this so the mechanism to make recommendations was for the TIGs, who were accountable to the ICB and therefore it was a collective decision to sign off the suggestions from the two TIGs. Tony Reeves added that we needed a process, which was transparent, that we all own not that the money went to different organisations in order plug gaps. We therefore need to concentrate on transforming the whole with a clear transparent commissioning process.

ACTION - Progress report to the next ICB meeting, including process update on mechanisms for supporting the fund, approach for confirming TIG priorities related to BCF so chance for ICB to sign off collectively and some clarity on decision making processes as part of ICB governance.

4 5 Year Strategy

a) HWB development session outcomes

The recent HWB session was the first of two development sessions which was around the 5 year strategy looking more broadly about how we operate as a collective board and whether we want/need to operate differently in terms of where we need to get to. Mike Farrar was invited to the session which was helpful, however a number of elected members were not present so Janice and Nancy had offered to meet with the elected members in order to bring them up to speed. This will take place before the 27th May second HWB development session and will focus on the model put forward by Mike Farrar. Kerry Weir also attended and gave a presentation on the 5 year strategy in terms of where she had got to which led to a detailed discussion. Kerry Weir referred to the NHS England template and HWB came to the conclusion that the template was not very helpful so it was decided that they would not use the template in the same way so Kerry is undertaking further work on the real strategic objectives that reflect our local position. Simon Large has some options and alternatives which were wider and broader than those being proposed.

Helen Hirst referred to the plan on a page and how this reflects the bigger challenges we have talked about in ICB. We have crafted the strategy around health outcomes and the challenge back is it didn't reflect our collective big challenge. We are reframing the 5 year plan and we still need to fill in the templates but we are missing the work from the CSU are doing on our behalf around whole system plans and strategies which is due back next week. Helen acknowledged it would be hard for NHS England because they are drawn in a different direction so what may be right for West Yorkshire may not be right for Bradford. We therefore need to make our voice collectively as to how we need to make it work for Bradford. It was noted there are challenges back at a national level where we have had to found work-around local solutions where process don't quite fit, such as the technology fund issue and some of the processes do not quite work locally and we are building up a small portfolio which we should use when talking to ministers etc. It was also about collectively not having to wait for permission all the time and being prepared to go on and do the right thing as we need to keep this journey going as it was in everyone's interest to do that. Simon Large felt this was really positive but was concerned about the practicalities of making it happen and how we were going to achieve this within the timescale. Tony Reeves was also interested in the strength of the evidence base to support the emerging themes from the strategy as well and felt that Public Health had a big role to play. It was noted we got to a

point at the end of the session on what is the big strategic thing around community, citizens and how we work collectively.

Helen Hirst added that there was a lot that happened outside this forum, we had all identified our planning leads through ICB previously and that there was an expectation that by 4th June plans should identify where we are not aligned and our task then would be to work on it so that by September we had coherent, aligned plans and strategy as NHS England and Monitor are expecting us to have an aligned position by then.

Phil Pue asked about the other organisations such as YAS including 111 whose strategies were not aligned with us, in addition to major private providers and wondered if there was any way of building in their strategies which have major impacts on our health and social care economy. Helen Hirst responded that there were lots of people who would be in the alignment discussion which was between big NHS providers and the commissioners. We need to find ways of engaging with YAS and Sue Cannon advised that this had recently been discussed at the West Yorkshire Leadership event and the YAS representative was going away to think about that. Tony Reeves was concerned that YAS were building in disconnects as they did not attend many meetings and suggested we needed to speak to senior people at YAS.

ACTION – Share CSU outputs next week with planning leads as nominated previously by ICB members

ACTION – Kerry Weir to `wordsmith' the documents based on HWB feedback ie objectives, values

ACTION – Ensure some of the feedback from CSU re provider plans gives us a richness to improve our overall narrative

ACTION – Present something back at ICB meeting on 16th May that sets out where we are not aligned and whether we have any chance of becoming so before June submission, or before September. Shape further at 16th May meeting before take into HWB 27th May. (Expectation that the planning leads work with Kerry to prepare this)

ACTION – Agreed overall principle that this is ICB's plan not CCGs/NHSE (not withstanding that we have to send to the forms in) and therefore iterations need sharing widely with ICB members

ACTION – Share above expectations of role of planning leads nominated by ICB

b) ICB Corporate Risk Register – working draft

Damien Kay and Lucy McKell had undertaken a joint piece of work pulling together a combined set of risks for ICB following the discussion at the last meeting and the suggestion to use a risk register approach framework so that ICB could think about those risks, prioritisation and how they could manage them collectively at an ICB corporate level. Lucy drafted a template and circulated this to nominated person in each organisation, responses had been received from everyone with the exception of NHS England in respect of primary care and specialised services. Sue Cannon agreed to take this away and respond. It was also proposed that YOR LMC be requested to highlight the primary care providers' key risks.

Damien and Lucy had received about 53 risks in total from respective organisations and these had been condensed to 20, but they had struggled with whether some were individual organisation risks or system risks. Assumptions had been made on the level of risk, who

owned the risk and ICB were asked to validate the risks, agree the scores and focus on the reds in terms of mitigation. Discussion on the identifier of the risks took place, but it was agreed this column should be removed as ICB should be the identifier for all collective risks.

Tony Reeves suggested that these should be reduced to 5/6 key risks as this needed to be viewed as a hierarchy with individual organisations risks sitting underneath. ICB needed to be collectively confident that there was robust risk management addressing the appropriate risks in each individual organisation but then leave it to those individual organisations to manage those and then concentrate on the cross cutting risks here. The issue for ICB was therefore a sustainability issue and our ability to manage them here.

Simon Large felt that this needed a lot of discussion and clarification together with joint understanding and the starting point for any risk register had to be what was the risk in relation to and it had to be a risk in relation to what we are achieving in our strategy and where we wanted to go and the risks in getting there. These risks are borne out of each organisation and their direction of travel so at the moment they are not owned by us corporately at the moment. For BDCT their main focus was around achieving Foundation Trust status which was a different risk for ICB corporately as the risk was did we want 3 Foundation Trusts on the patch, what was the consequence of having 3 on the patch and how does it help/hinder our joint strategic objective of providing sustainable health and social care services in 5 years' time and there has to be a debate in order to get into the detail. He therefore suggested we needed to take that same approach across each risk.

A debate was therefore needed regarding sustainability across the district and whether we could deliver our ambitions in the emerging strategy. The key things were a combination of clarity around our resource position/transforming our approach/early interventions/demand management/behaviour change then appropriately and productively targeting our resource deployment to get us to a sustainable situation.

Until the 5 Year Strategy was in place we cannot finalise the strategic risks so Tony Reeves felt we should aim to have back on the June meeting alongside the strategy. Once we had all signed up to, and collectively own, the 5 Year Strategy then it was incumbent upon individual organisations to realign their individual plans so that collectively we were covering all the gaps. There was a collective responsibility to get the whole thing aligned in terms of our strategic planning, budget and resource redeployment in order to drive the culture change.

ACTION - Chase up response from NHS England regarding specialised services.

ACTION - Request primary care input via LMC representative

ACTION - Undertake a re-shape of the draft Risk Register in light of comments received and condense to identified 5/6 key risks. Once strategy is clear then finalise strategic risks. Plan to consider alongside strategy at June ICB.

ACTION - Over next few months ICB progress alignment of plans, strategy, risk register and resources.

14/16 ICB Forward Plan

Damien Kay indicated the last discussion helped with the ICB forwarding planning particularly in respect of a big push over the next 2/3 months and what needed to come back here in terms of the strategy and dovetailing the risks. This plan was still being used in the

absence of having that programme managed approach in order to ensure that nothing slipped.

Tony Reeves felt that the earlier point about formalising the reporting relationships and accountabilities with the TIGs was really important and thought that someone needed to have that conversation with the TIGs in order to develop some proposals around that. Damien Kay added that there was also the tech fund and urgent care in addition to other strands so it was felt that we needed an accountability framework. As we move forward Tony Reeves believed that accountability would become progressively more important particularly once the Strategy was set and the implementation plans were running our role would be more about monitoring and shaping as we go forward. Simon Large agreed that over time we would see this forum starting to put some expectation into TIGs, Urgent Care Board, etc about what we wanted to see and the work that needed to happen at a local level.

Janice Simpson felt that formal exception reports on progress should be brought back from the four high level work streams. Tony Reeves said that Lucy McKell and Damien Kay would build this into the programme management framework which we would see next time as there were some broader accountabilities and it was about the key dependencies against the overall Strategy that we ended up with.

Janice also thought that the Section 117/CHC should be taken off the 16th May agenda as following discussions it was did not seem a very helpful debate to have here which everyone agreed with.

ACTION - Accountability framework required which picks up all key dependencies. Lucy McKell and Damien Kay to build in to framework re key dependencies against overall strategy so get relationships right with TIGs, Urgent Care and once strategy is set and ICB moves into monitoring role.

14/17 ANY OTHER BUSINESS

Simon Large advised that at the last meeting the arrangements were set up for our organisations' boards to consider the 'Better Care for Bradford, Airedale, Wharfedale and Craven' document. He confirmed that the BDCT board had received and approved the document but had some questions in respect of seeking absolute clarity around governance arrangements, delivery of the project, timescales, milestones in order that they understood where they fit and contribute to that and the expectations around it. Both BTHFT and AFT confirmed their board had received and approved the document and Bridget Fletcher confirmed feedback has been provided.

14/18 NEXT MEETING

Friday 16 May 2014, 9.00-12.00, Douglas Mill room 1.1

Action	Lead	Deadline
Primary Care Representation Progress Chief Exec of YOR LMC undertaking primary care representation as member of ICB on the basis there is a mandate from primary care and this is their preferred model.	CCGs	ASAP
System Mentor Role Collectively commission Mike Farrar through HWB as system mentor – 5 session per year (3 sessions @ HWB and 6 monthly ICB)	Nancy O'Neil	May 14
Better Care Fund Progress report to the next ICB meeting, including process update on mechanisms for supporting the fund, approach for confirming TIG priorities related to BCF so chance for ICB to sign off collectively and some clarity on decision making processes as part of ICB governance.	Janice Simpson	16.05.14.
5 year strategy <u>HWB session & CCGs Strategy – unit of planning</u> Share CSU outputs next week with planning leads as nominated previously by ICB members Kerry Weir to `wordsmith' the documents based on HWB feedback ie objectives, values etc. Ensure some of the feedback from CSU re provider plans gives us a richness to improve our overall narrative Present something back at ICB meeting on 16th May that sets out where we are not aligned and whether we have any chance of becoming so before June submission, or before September. Shape further at 16th May meeting before take into HWB 27th May. (Expectation that the planning leads work with Kerry to prepare this) Agreed overall principle that this is ICB's plan not CCGs/NHSE (not withstanding that we have to send to the forms in) and therefore iterations need sharing widely with ICB members Share above expectations of role of planning leads nominated by ICB <u>ICB Corporate Risk Register – working draft</u> Chase up response from NHS England regarding specialised services. Request primary care input via LMC representative	 Kerry Weir Kerry Weir Planning leads Kerry Weir and Planning leads Kerry Weir/Damien Kay Helen Hirst/Damien Kay Sue Cannon Damien Kay	 30.04.14. Early May 16.05.14. 16.05.14. Ongoing ASAP

Undertake a re-shape of the draft Risk Register in light of comments received and condense to identified 5/6 key risks. Once strategy is clear then finalise strategic risks. Plan to consider alongside strategy at June ICB. Over next few months progress alignment of plans, strategy, risk register, and resources.	Lucy McKell/Damien Kay ICB	June 14 April – June 14
ICB forward plan Accountability framework required which picks up all key dependencies. Lucy and Damien to build in to framework re key dependencies against overall strategy so get relationships right with TIGs, Urgent Care and once strategy is set ICB moves into monitoring role.	Lucy McKell/Damien Kay	June 14

Health & Social Care Partners in Bradford, Airedale, Wharfedale & Craven

Action notes of the Integration and Change Board (ICB)
held on Friday 16 May 2014
9.00-10.40 at Douglas Mill

Present:	Tony Reeves (Chair)	Chief Executive, BMDC
	Bridget Fletcher	Chief Executive, AFT
	Helen Hirst	Chief Officer, Bradford CCGs
	Damien Kay	CCG Collaboration Senior Lead, Bradford & Airedale CCGs
	Nancy O'Neill	Director of Collaboration, Bradford & Airedale CCGs
	Janice Simpson	Strategic Director, Adult & Community Services, BDMC
	Sue Pitkethly	Chief Operating Officer, AWC CC
	Anita Parkin	Joint Director of Public Health, BMDC
	Dr. Phil Pue	Chief Clinical Officer, AWC CCG
	Ann Wagner	Director of Strategy & Business Development, AFT
	Liz Romaniak	Director of Finance, BDCT
	Simon Large	Chief Executive, BDCT
	Sue Cannon	Director of Nursing and Quality, WYAT NHSE
	Michael Jameson	Strategic Director of Children's Services, BMDC
	Dougy Moederle-Lumb	Chief Executive, YOR LMC
In attendance:	Cath Doman	For agenda item 3
	Dr Andy Mc Elligott	For agenda item 4
	Kerry Weir	For agenda item 5
Apologies:	Bryan Millar	Chief Executive, BTHFT
	Juliette Greenwood	Chief Nurse, BTHFT
	Dr. Akram Khan	Clinical Chair, Bradford City CCG
	Dr. Andy Withers	Clinical Chair, Bradford Districts CCG

1. MINUTES OF THE MEETING HELD ON 25 APRIL 2014 AND MATTERS ARISING

The minutes were agreed as an accurate record of the meeting.

It was noted there is an outstanding action to brief the elected members who could not attend the HWB workshop in April – Janice Simpson/Nancy O'Neill (Before 27th May). All other actions are completed or part of the agenda for discussion.

2. MATTERS ARISING

a) Primary Care Representation at ICB

This has been actioned and Dougy Moederle-Lumb is present at the meeting as a result. The Terms of Reference will be updated to reflect additional membership.

b) System Mentor Role

The System Mentor role has been picked up in discussion with Mike Farrar and he has agreed to deliver 2 sessions for ICB at 6 monthly intervals. The ICB agreed that he will be invited to the September 2014 ICB meeting.

ACTION: Mike Farrar to be invited to the September (19th) ICB meeting; link into Forward Planner – Nancy O'Neill/Damien Kay (to action).

3. PROGRAMME MILESTONE PLAN

Cath Doman was in attendance to present the programme milestone plan (developed through Lucy McKell). After discussion the ICB agreed that the plan is helpful and useful in capturing where we are at; however the following suggestions were made to develop the plan further:

- Clarity needed in terms of where the dates align.
- A Gantt chart would lend further clarity in terms of being able to have view of the key dependencies and critical paths which would inform integration and transformation changes and our ability to plan and align resources.
- The plan is missing self-care and out of hospital care, integration (including primary care), planned care and these should be part of the plan.
- The plan needs to capture 'Transformation' as well as the focus on integration in order to make an impact. This is the key to sustaining the whole system.
- The plan needs to be re-organised to pick up higher level system transformation and to align through Children's services, and enablers such as workforce as well as the TIGs.
- Although the plan reflects the 4 strands of work, it also needs to reflect the synergy between Bradford and Airedale programmes such as single point of access (accepting that there will be some differing milestones).
- Acknowledge that most of the RAG rated green areas will move to red/amber as we being to fully implement the programme approach.
- Important that more work is done on the key activities, dependencies, critical paths and critical decision-making to inform the plan (and appropriate deployment of resources).
- The milestone plan should be linked to the 5 year plan and reflective of the work that is going on and then this should feed into the work programme.

It was agreed that a small group should meet separately from the ICB and attempt to put together more detail for the milestone plan to align both the milestone plan and 5 year strategic plan. Kerry Weir is currently organising a meeting to discuss 5 year strategy and it was agreed that the group she assembles will join with additional key people to work together on alignment of plans. It was agreed that this item will come back to the ICB meeting on 20th June.

ACTION: Milestone plan to be integrated into a Gantt chart to provide visual clarity around key activities, dependencies, critical paths, critical decision-making to inform the ICB plan.

ACTION: Link into the work being undertaken on the 5 year strategy, led by Kerry Weir, to identify gaps and develop a milestone plan that reflects key strategic work streams that will be overseen by ICB

ACTION: Bring milestone plan back to next ICB meeting; 20th June.

4. INTEGRATED DIGITAL CARE RECORD (IDCR)

Dr Andy McElligott was in attendance as Chair of the IDCR Programme Board to brief the ICB on the IDCR. A paper was circulated with the agenda for members information and Andy shared IDCR planning and indicative timelines across the workstreams.
Andy confirmed that the IDCR is a key enabler for the delivery of Integrated Care for Adults; as a CCG and LA supported strand of work. The IDCR aims to enable a shared record environment across Bradford, Airedale Wharfedale and Craven in which information about an individual's interaction with services within Health and Social Care will be made accessible to all practitioners who have a legitimate relationship with that individual (subject to patient consent).

Historically, in 2013 the Department of Health and NHSE announced that they would provide technology funding to accelerate the digital maturity of the NHS to facilitate the move towards a paperless organisation. ANHST, BTHFT, BDCT and BMDC submitted expressions of interest and were awarded over £6m capital funding (to match fund existing revenue streams) plus the opportunity to be a national accelerator site.
No monies were actually awarded and after a delay in identifying a clear route for the funding NHSE suggested that the BDMC' previous application should be re-considered as part of the 'Wave 2' applications in 2014 (See paper for further information). Andy will be contacting NHSE with regards to the original promise of funding.

Interviews took place recently with the aim of recruiting a project manager however no appointment was made. It was decided that the work has moved on significantly since a project manager was suggested to work across the work streams. Each work stream now has a project manager so it now viewed as not cost effective to recruit another. Kathryn Lamb in her role can make connections across the cross district work and is happy to pick this up. Discussion took place on the technical joining up of the system and whether a project manager could fulfil that role and it was suggested the programme board should consider what will work across the system including issues supporting technical delivery.

In terms of governance arrangements, each organisation have an individually signed Memorandum of Understanding (MoU) and are accountable individually for their areas of work; however collectively the partners are all accountable. It was recommended that the collective partnership should be accountable to the ICB (given the national profile). This doesn't exclude the TIGs from having input into the process.

Benefits realisation has been looked at individually but now needs to be scrutinised as a whole programme. This was not articulated enough during the bidding process.

During discussion it was noted that Children's social care was not included at Wave 1; it was suggested that Children's could be added at Wave 2. All agreed that it would be beneficial to include children's social care at Wave 2 however the need to be mindful of any detrimental effect this could have on the Local Authority Wave 2 bid was recognised. It was noted that Bradford Hospitals Foundation Trust have received resources but are stitched into the partnership element of the bid but are understood to be looking at wave 2.

It was agreed that to take this work forward it is important to clarify the benefits and what success is going to look like. This work will remain as ongoing and report through the programme arrangements with the option to come back to ICB to report on an exception basis.

ACTION: Governance – report into ICB key milestone decisions through wider programme arrangements, with direct reporting into ICB by exception where need specific decisions – Andy McElligott/Lucy McKell/Kath Lamb

ACTION: Programme Management – ICDR programme board to consider what will work re programme management arrangements and achieve system wide approach, including issues supporting technical delivery. Fine tune programme management arrangements as necessary

ACTION: Wave 2 – opportunity to include Children's social care and for BHT access to resources/funds to be explored in respect of Wave 2 – ICDR Programme Board

ACTION: Benefits Realisation – whole system benefits to be developed to promote collective benefits – ICDR Programme Board

5. 5 YEAR STRATEGY

Kerry Weir talked members of ICB through a number of slides to illustrate areas of ongoing work towards developing the health and care 5 year strategy, focusing on work that still requires action and how to complete the actions before the end of June (paper disseminated prior to ICB meeting). Kerry confirmed that following development sessions that have taken place with the HWB and ICB the plans have been revised to build on the collective views and inputs.

The first draft of the Ernst and Young model has been received; there are still a few gaps, but it will be a good starting point in terms of estimates to facilitate quantification. Discussion took place on the disappointment with what has been provided back via the CSU and it was noted the CSU will be required to undertake the quantification element of the `number crunching' bit to support the strategy development e.g. productivity.

Kerry suggested that the ICB need to be clear on what outcomes are required from the HWB event on 27th May. There is more work to be done before a submission on 20th June can go ahead and it was agreed the priority is to ensure that all organisations are working together in the same direction as a Health and Social Care economy. Further clarity in terms of level of detail is expected for September 2014 submission.

Discussion took place on the absence of SMART objectives across number of strategies that has been analysed including the HWB strategy and the need to challenge ourselves on developing the right objectives which we can measure and test out. It was noted we need to put some numbers into the submission for 20th June but they will be assumptions that we all understand and with a set of work programme to deliver. Kerry added that view of the community strategy would aid alignment across the patch. It was suggested that Kerry contact Imran Rathore (LA) who is currently reviewing the community strategy(interventions and numbers) in terms of alignment with Kerry's work.

A detailed discussion took place around:

- What to take to the HWB
- The need for agreement on what needs to be modelled
- Feedback to CSU
- Whether practices need to be looked at
- Should PbR be suspended and a different mechanism of payment employed.
- Obtaining a view from the HWB (including politicians) – level of and appetite for change.
- Making HWB (including politicians) aware of the real issues/stumbling blocks.

It was recognised that the problems faced by the organisations across the patch are not unlike those faced across industrialised system and the way forward would be to deal with the issues that can be dealt with, that are in our gift and be honest in our submissions in terms of what we can do. Access to relevant information is needed to make credible decisions. It was noted that the ICB acknowledge that submissions on 20th June will not be complete and gaps will be evident however it was also noted that a demonstration of being able to identify what the gaps are and to submit plans and timescales around them would establish credibility to take this forward (feed this back to NHSE).

Kerry agreed to organise a whole day planning event with relevant representatives who can offer the appropriate input into the plans. Tony Reeves made a plea that all relevant staff must prioritise the whole day working group session. Greg Fell (Public Health) will also be invited to contribute to planning. It was also suggested that Damien Kay approach Wakefield to learn from their actions in terms of the BCF and strategic plans.

ACTION: Whole day event to be organised for ICB nominated planning leads to develop 5 year plan including aligning provider plans, ensuring appropriate input/representation including public health. May HWB session used to take members with us not sharing the detail and take formally into HWB in July following 20th June submission – Kerry Weir.

ACTION: Approach Wakefield for a view of their collective strategy – Damien Kay

(Tony Reeves left the meeting at approx. 11:05 – Simon Large took over the position of Chair)

6. Oliver Wyman Update

Phil Pue gave the ICB an overview of the progress so far with the Oliver Wyman Model (See paper disseminated prior to ICB meeting).
This work began across the Airedale patch after agreement that it is an opportunity to do something different in terms of Transformation and Integration. Phil Pue and Bridget Fletcher met with Jeremy Hunt to introduce him to the model and request funding; he displayed interest however no funds were received. Support was offered from NHSE to move forward with a piece of work on different care models.
AWC have had 2 workshops; 1 on the 10th April and the second on 15th May which were well attended by Primary Care providers, GPs, BDCT, BTHFT, LA, YAS, NHSE AT, LMC and LCD. The attendees were asked to think about what would make a difference to what is already being done (their organisational 'hats' aside). The first workshop focussed on local data. It was hoped that by collation of the data would reveal a picture of what the Health and Social care would look like overall. However there was a lack of access to data from areas including Mental Health, Social Care or Community data, (information may be skewed). Phil summarised the Extensivist model and the Enhanced Primary Care model. The second Oliver Wyman workshop occurred yesterday and he and Bridget have not yet had the opportunity to take stock of the workshop outcomes.
After discussion the ICB agreed that the an exploration of the Extensivist capabilities together with Enhanced Primary Care could prove complimentary to each other – it would involve proactive working and include all areas of health and social care. Further discussions covered areas that will be considered:

- Accountability
- 7 day care / possibly 24hr in areas
- Early interventions
- Financial incentives
- Money back into primary care

Phil Pue confirmed they want to progress and for implementation they will need to put resources in and could tap into NHSE transformation accelerator programme and they are expressing interest in co-commissioning of primary care so they have more say in commissioning of primary care. There needs to be a clear vision of what this looks like so it can be described to people and they need organisational sign up and it must be built into the strategic plans. AWC CCG will direct funding towards this and any non- recurrent resources, primary care resources to support this as well as using BCF to facilitate this will be looked at. A team will be pulled together to design what this might look like and it needs building into ICB project plan and Airedale TIG will lead planning and oversee and report into ICB. In terms of timescale the vision will be developed over the next month or so, with design and a plan for it over next 4 months with something up and running by the end of the financial year.

ICB discussed whether by building this in the strategy we could extrapolate the number over a larger footprint and relationship with unit of planning. It was confirmed there is an evidence base behind this and enthusiasm from clinicians. It was noted it will be useful for Bradford to be part of this and Bradford may wish to contact Oliver Wyman.

Bridget Fletcher confirmed this model is about putting structure into an unstructured system and there is a need to crack how doctors work together and differently given we can't overlay a new system and it is about how we use current ones.

Feedback was given on the use of different language and whether this varied from what is taking place and how much different this is to the Bradford Integrated Teams and needs co-designing and economic modelling to see if will deliver and it was noted it is a challenge to describe this is a way that can be clearly understood.

Helen Hirst confirmed it would be useful for Bradford CCGs to at least undertake some of the analysis and can see some of the future model of primary care and leaning towards shifting urgent care to being more planned type care but need to create incentives but there are risks/consequences of this.

It was agreed AWC TIG will build this into the 5 year strategy and the Bradford end will take via Bradford TIG and take into clinical boards, work via TIG leads in terms of perception and commit resources to doing the analysis.

ACTION: Need to build this work into strategic plan from AWC TIG perspective – Sue Pitkethly/Kerry Weir

ACTION: Bradford Clinical Boards to be briefed about Airedale/Oliver Wyman plans and work with TIG to test perceptions and build into thinking – Helen Hirst

ACTION: Bradford CCGs to commit resource to consider progressing Oliver Wyman Analysis – Helen Hirst

ACTION: Feedback on progress towards implementation from AWC TIG into ICB – Phil Pue

7. Better Care Fund

Nancy O'Neill confirmed that the issue remains with the BCF is how to link it back to the 2 year plan and 5 year strategy plan process. Jane Hazelgrave has asked the West Yorkshire Audit Consortia (WYAC) to undertake some work to identify possible options in terms of the holder of the pooled fund. They will look at what other areas have agreed to do and the technicalities, pros, cons, benefits and risks of where the pooled fund will ultimately sit. The

ICB agreed that this must be made simple and sufficient trust will be needed. The WYAC are expected to complete this work in July (pooled funds to begin 1st April 2015).

The decision-making process i.e. who decides where the funds will be used is being looked at as requested at the last ICB meeting to understand existing ICB governance arrangements. Janice Simpson confirmed that she and Damien Kay have been undertaking exploratory work in terms of identifying what areas have been involved in BCF planning linked to integration governance structures. It looks at the governance arrangements (HWB down) and includes a track of where BCF discussions have taken place (meetings) to identify where decisions are being made.

In doing this piece of work it was realised that there are lots of groups involved in the discussions around BCF planning . After discussion the group agreed that:

- Graphical demonstration of the current groups will be useful
- The structure needs to be fit for purpose
- Identify permanently structured groups with clear terms of reference.
- Need clarity on the tiers of decision-making
-

Discussion followed on the submitted BCF plan which has been drawn up and which gives a broad indication of planned areas where the funds could be utilised; but is still lacking in detail as yet and we need to agree how to move to a set of aligned plans which make the best use of resource for our collective system.

Following discussion on how to progress development of a set of aligned BCF plans across HWB system it was acknowledged there is a need to achieve consistency and bring together how we achieve a system wide approach to BCF plans even if components within it are locality specific so at HWB level it can make sense.

It was confirmed that the Directors of Finance have been working up a set of evaluation criteria to apply rigour and assess costs, benefits and risks of the range of BCF proposals developed through both TIGs. To move this on it was agreed a Task and Finish' group is set up and tasked by ICB to undertake work involving a couple of the Finance Directors, representatives across the TIGs and the Local Authority to pull BCF plans together and ensure that the whole system is aligned form BCF plan perspective. The results of Task and Finish group will come back with recommendations to June ICB meeting.

It was noted we need to get BCF governance fit for purpose and if TIGS want to do something significantly different then it needs to be recommended to ICB for sign off at HWB (Not yet known `final' BCF plans if it goes to NHSE and DoH for final sign off following stocktake**). POST MEETING NOTE – BCF to be re-submitted 27/6/14.**

Finally, Damien Kay and Janice Simpson invited comments on the draft paper re structures and governance separately via e-mail.

ACTION: Develop a graphical demonstration of all the relative group meetings and ensure the governance is fit for purpose (and how it links into 5 year plans) to come to future ICB meeting - ICB Task and Finish Group - DK/L McKell.

ACTION: Task and Finish Group including 3 Reps from each TIG, Local Authority, 2 FDs to pull the respective TIG BCF priorities to align and bring to ICB June meeting to make recommendations for HWB to sign off - Janice Simpson/Cath Doman/Phil Pue

ACTION: Governance Structures - outside of ICB comments to be sent to Janice Simpson and Damien Kay via email.

8. ICB Forward Plan

Damien Kay discussed items that are currently on the planner which was disseminated with the ICB papers. It was noted that the milestone plan which is being developed by Lucy McKell and Damien Kay, will eventually merge with and replace the current forward plan. In terms of support, a portfolio manager post plus 2 support posts are going out to advert.

ACTION: Mike Farrar to be invited to the September (19th) ICB meeting – Nancy O'Neill

ACTION: Milestone plan coming back in Gantt chart form to ease scheduling – Damien Kay/Lucy McKell

9. Any Other Business

Information Governance - Janice Simpson reported that Heather Lomax attended the HWB and requested that IG could be placed on the ICB agenda for discussion to ensure support from the ICB members in terms of ensuring that we have a clear IG arrangements across the system.
Kath Lamb is pulling together a meeting of the information governance leads to look at the implications around the new Integrated Digital Care Record and Ann Wagner agreed to take this back into the next Board of IDCR.

10. Next Meeting

Friday 20th June 2014, 9.00-12.00, Douglas Mill room 1.1

ICB Key Actions – 16th May 2014

Action	Lead	Deadline
2. Minutes and Action Plan: **HWB Session** • Outstanding Action: Brief the elected members who could not attend the H&WBB workshop. **System Mentor Role** • Mike Farrar to be invited to the September (19th) ICB meeting – link into Forward planner.	 Nancy O'Neill/ Janice Simpson Nancy O'Neill/ Damien Kay	 Before 27th May ASAP
3. Programme Milestone Plan • Milestone plan to be integrated into a Gantt Chart to provide visual clarity around key activities, dependencies, critical paths, critical decision-making to inform the ICB plan. • Link into the work being undertaken on the 5 year strategy, led by Kerry Weir, to identify gaps and develop a milestone plan that reflects key strategic work streams that will be overseen by ICB • Bring plan back to next ICB meeting	 Lucy McKell Kerry Weir/Lucy McKell/ Cath Doman/Damien Kay	 Before 20th June Before 20th June
4. Integrated Care Digital Record Briefing • Governance – report into ICB key milestone decisions through wider programme arrangements, with direct reporting into ICB by exception where need specific decisions • Programme Management – ICDR programme board to consider what will work re programme management arrangements and achieve system wide approach, including issues supporting technical delivery. Fine tune programme management arrangements as necessary • Wave 2 – opportunity to include Children's social care and for BHT access to resources/funds to be explored in respect of Wave 2 • Benefits Realisation – whole system benefits to be developed to promote collective benefits	 Andy McElligott/Lucy McKell/Kath Lamb ICDR Programme Board ICDR Programme Board ICDR Programme Board	 Ongoing Ongoing In line with Wave 2 timescale TBA
5. 5 year strategy • Whole day event to be organised for ICB nominated planning leads to develop 5 year plan including aligning provider plans, ensuring appropriate input/representation including public health. May HWB session used to take members with us not sharing the detail and take formally into HWB in July following 20th June submission. • Approach Wakefield for a view of their collective strategy	 Kerry Weir (on behalf of ICB) Damien Kay	 ASAP ASAP

6. Oliver Wyman Update • Need to build this work into strategic plan from AWC TIG perspective • Bradford Clinical Boards to be briefed about Airedale/Oliver Wyman plans and work with TIG to test perceptions and build into thinking • Bradford CCGs to commit resource to consider progressing Oliver Wyman Analysis • Feedback on progress towards implementation from AWC TIG into ICB	Sue Pitkethly/Kerry Weir Helen Hirst Helen Hirst Phil Pue	June 2014 Week commencing 19th May Ongoing
7. Better Care Fund • Develop a graphical demonstration of all the relative group meetings and ensure the governance is fit for purpose (and how it links into 5 year plans). • Task and Finish Group including 3 Reps from each TIG, Local Authority, 2 FDs to pull the respective TIG BCF priorities to align and bring to ICB June meeting to make recommendations for HWB to sign off • Governance Structures - outside of ICB comments to be sent to Janice Simpson and Damien Kay via email •	ICB Task & Finish Group (LMcK/DK) Janice Simpson/Cath Doman/Phil Pue ICB members	In line with strategy development Before 20th June Before next ICB meeting
8. Forward Planner • Mike Farrar to be invited to the September (19th) ICB meeting • Milestone coming back in Gantt Chart form to ease scheduling	Nancy O'Neill Damien Kay/Lucy McKell	May 2014 20th June