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

Action notes of the Integration and Change Board (ICB)
Friday 19 December 2014
9.00 - 12.00 at Douglas Mill

Present:	Helen Hirst (Chair)	Chief Officer, Bradford CCGs
	Dr Phil Pue	Chief Clinical Officer, AWC CCG
	Damien Kay	CCG Collaboration Senior Lead, Bradford & Airedale CCGs
	Sue Pitkethly	Chief Operating Officer, AWC CC
	Juliette Greenwood	Chief Nurse, BTHFT
	Liz Romaniak	Director of Finance, BDCT
	Dougy Moederle-Lumb	Chief Executive, YOR LMC
	Clive Kay	Chief Executive, BTHFT
	Karl Mainprize	Medical Director, ANHSFT
	Simon Large	Chief Executive, BDCT
	Anita Parkin	Joint Director of Public Health, BMDC
	Dr Akram Khan	Clinical Chair, Bradford City CCG
	Bridget Fletcher	Chief Executive, ANHSFT
	Michael Jameson	Strategic Director of Children's Services, BMDC
	Janice Simpson	Strategic Director, Adult & Community Services, BDMC
	Nancy O'Neill	Director of Collaboration, Bradford & Airedale CCGs
In attendance:	Cath Doman	Programme Director, Integrated Care, Bradford CCGs
	Andrew Messina	Portfolio Manager, Bradford CCGs
	Clare Smart	Head of Service Improvement, Bradford CCGs
	Greg Fell	Consultant in Public Health, CBMDC
Apologies:	Bill McCarthy	Deputy Vice Chancellor, University of Bradford
	Dr Andy Withers	Clinical Chair, Bradford Districts CCG
	Sue Cannon	Director of Nursing and Quality, WYAT NHSE
	Jane Hazelgrave	Chief Financial Officer, Bradford CCGs
	Rod Barnes	Deputy Chief Executive & Director of Finance & Performance, YAS
	Steve Evans	Acting Asst. Director Transformation, NYY County Council

2. MINUTES OF THE MEETING HELD ON 21 NOVEMBER 2014 AND MATTERS ARISING

The minutes of the last meeting were agreed as an accurate record pending the following:

- amendment to minor typographical error pg2
- ensure minutes and action notes consistently state Feb 15 as the deadline date for taking Urgent and Emergency Care Strategy through individual organisations governance processes

Cath Doman briefly updated the group regarding the latest BCF submission. This is currently with NHS England with a recommendation for full approval.

ACTION:

- Amend minutes and action notes as above.

3. BRINGING THE RISK REGISTER TO LIFE

a. ICB Risk Register sign off

Andrew Messina has worked with colleagues to modify the register based on feedback from the October 2014 meeting. A lead ICB member has been identified against each action and an additional column has been created for residual risk which includes proposed ratings.

Dougy Moederle-Lumb shared a perspective from the LMC in terms of the recognition by primary care of the need for significant change to be implemented and to operate at scale. It was noted the LMC role on ICB is different to other ICB members as Dougy fulfils the role of head of a representative organisation, as opposed to being head of either a commissioning or provision organisation, and therefore he is here as an influencer and leaders of GPs and will continue to use that role. Dougy shared a view with ICB regarding the challenges within primary care given increasing workload and workforce issues which are creating some real pressures in the system. In terms of the national 5YFV it was acknowledged this isn't recognised fully across the whole of primary care and the LMC is working to raise the vision for change through a variety of means such as roadshows, supported by Hempsons and the CSU. Linked to this a discussion took place on language being used and it being different to what primary care are used to, and at times difficult to understand even when operating in the system. ICB acknowledged the need for a clear and consistent narrative to support better engagement and agreed to work quickly to develop shared communication about the system-wide work being led by the group, reasoning behind decision making and intentions going forward. This will be taken forward by the ICB sub group at its next meeting and resource will be identified to support the work.

ICB fed back on the updated risk register, commenting on the good progress made and acknowledging it is a work in progress. Members considered the names identified against risks, noting at this current stage of development it is to provide a level of assurance that a named individual holds responsibility for keeping the risk in sight as plans progress. As the work plan is refined the most appropriate name will be identified for each action and therefore the named individual may change. Supporting information is required that provides explicit reference of the resource allocated to delivering each line. This will enable the named ICB member to gain assurance through leadership and oversight of the delivery mechanism.

At this stage the majority of risks are rated at Red however this is to be expected given the long term nature of goals. The ICB does need to be able to see where there is movement and action taken. Andrew will continue to work with ICB members and other colleagues to develop the register, the mechanism for progressing work and identification of resource to support delivery.

ACTION:

- Development to continue in terms of mechanism for progressing work including explicit reference to resource to support delivery of each line. For discussion at February ICB
- Development of consistent narrative on work of the ICB, reasoning behind decision making and intentions going forward, adaptable for use internally, externally, locally and nationally. Fast turnaround required. (linked to item 7)

b. 2 things to tell

This will be a regular item on the ICB agenda providing an opportunity for members to share information about anything that has happened in their part of the system which impacts or mitigates something on the risk register. Information was shared as follows:

- A system-wide meeting took place where providers and commissioners managed to align commissioning intentions across organisations and with the local 5YFV
- Regional work continues through other forums e.g. for urgent care, stroke, paediatrics etc. Linkages are key with this wider work to ensure benefits and opportunities can be capitalised upon and any risks and impacts addressed.
- A focussed meeting took place with the Council Executive around integration, a second meeting is planned. Cllr Andy Thornton is their lead for transformation and change. The Council continues its New Deal for Communities conversations with the public to achieve financial alignment and develop the vision for the Council over the next 3-5 years. ICB work needs to align with this as it develops.
- Member practices in AWC continue to explore federated models of working
- Oliver Wyman work – AWC will be visited on 13th Jan by colleagues from the USA who are involved in implementation of new models of care which have been explored by the New Models of Care Learning Network. Phil Pue agreed to share details of the visit with Bradford clinical board GPs who are welcome to attend
- The Bradford CCGs are holding a joint clinical board meeting to discuss and explore new models of care. It was noted both Bradford CCGs are applying for full delegation of primary care co-commissioning.
- BTHFT updated on progress regarding the workforce strategy which has had a scoping session and the LETB are engaged in the work and will be providing support and input.
- In response to workforce risk in terms of attracting staff to the locality, the Local Authority has begun some work involving all parts of the system looking at how the Bradford district is promoted. ICB organisations are committed to this agreeing it needs to align to ICB Workforce Strategy as it develops. It noted several ICB organisations are members of Bradford Breakthrough who are driving their "Producer City" scheme forward. Links need to be made across all streams of work.
- Potential opportunities in getting engagement from national bodies/level. Raised with Simon Stevens/Ian Dodge who are encouraging economies to raise issues/blockages with them.
- Emerging risk of impact of CQC inspections of nursing homes and stability of the market. This is on CCG risk registers and discussions are taking place regarding developing the market, but as yet the solutions are not clear.
- Consideration was given to ICB members approach to leading their individual lines of delivery and overall leadership of ICB work across the system. ICB is at the beginning of turning ICB work into the 'day job' and galvanising programme management etc – it was agreed this is an issue across the risk register and there is still work to do, but as it is the register provides a lot more consciousness for individuals on their `allocated' risk areas
- Monitor will visit BDCT in January in relation to their bid for FT status. Discussions have taken place with Monitor considering how emerging ICB discussions fit with BDCT ambitions.

ACTION:

- Visit to Airedale as part of Oliver Wyman work to discuss how the model worked in the USA. Bradford CCGs clinical board members to be invited to attend 13th Jan workshop
- Establish linkages within system wide workforce strategy – commitment from partner organisations to input to development of a "promoting positive Bradford" via work being led by Michael Jameson

c. TIG Highlight Reports

i. Bradford

No report as the meeting was cancelled due to a high number of apologies.

ii. AWC

Phil Pue directed the group to the previously circulated written update from the meeting. In particular Phil highlighted work from the New Models of Care Learning Network (NMCLN) and noted that AWC CCG has been invited to apply for Integrated Care Pioneer Site, Phase 2 and the TIG has agreed to go ahead with an application supported by member organisations. This will allow them to remain engaged with the national system once the NMCLN ceases at the end of March 15.

4. BETTER FOR BRADFORD METRICS – ABILITY TO MEASURE IMPACTS

Cath Doman took the group through the current position of key health and care system-wide indicators and the impact of the portfolio of programmes on these indicators. The metrics have arisen from the BCFs monitoring requirements, plus additional local indicators felt to be representative of whole system change (Cath was asked to check BCF-based metrics are the latest). It was noted that the population used is the HWB footprint and therefore doesn't include Craven data. Cath impressed that due to the infancy of the portfolio of programmes, with some still being scoped, there is little demonstrable impact at this stage. This is expected to change as plans are firmed up and it is suggested the report returns every 6 months to provide assurance to the group.

ICB noted the content of the dashboard and the associated report. Discussion took place regarding the metrics in use and whether any further assurance is required through additional indicators which would better reflect the full spectrum of the portfolio and emerging new models of care. The group agreed these are a starting point and will develop along with the scope of each programme.

It was agreed that a wider breadth and depth of data is required but it is not possible to identify all elements now. A summary analysis describing what the data means would be helpful and ICB want to receive this on a monthly basis with planned time for discussion at ICB on a quarterly basis (rather than at the suggested 6 month intervals). It was noted that this report is high level and does not reflect the full dashboard which contains much more detail. It will be possible to deep dive into the underpinning data, and focus on specific areas. This would be supported through taking a holistic view across services and the totality of dashboards available. It was suggested indicators could be developed for each programme and it was noted this is at a state of development with a need to be more ambitious and specific and if we are smart in how we design these they could link into the thinking for the design of CQUINS etc. It was suggested this links to the need for system-wide analytics and the possibility of incorporating this for discussion at Feb ICB, including resourcing.

The group need to be confident that the report and dashboard developed provide enough detail to give assurance that actions are being delivered and the data to flag where further actions are required. The data looks at the last 6 months and a longer lead in time would provide context and more meaningful information.

ACTION:

- Future iterations of the report to cover wider breadth and depth of data, informed by discussions about each programme and agreement on what metrics will provide ICB with assurance. Include summary analysis narrative describing "what this means" and historical data for context.

- ICB to be sited on performance on a monthly basis, with discussion on the agenda on a quarterly basis.
- Discussion re system wide analytics to feed into Feb ICB discussions, including resource need.
- Ensure metrics in the report are based on current BCF plan

5. UPDATE ON SELF CARE PROGRAMME SCOPE

Greg Fell took the group through the previously circulated draft strategy for self care formulated through work led by Public Health with widespread input and involvement of most to all of the relevant stakeholders. The ICB originally requested scoping was done around self care and prevention but given the wide ranging and often ill-defined nature of these terms initial work has focused on self care. Future work will be done on prevention.

Greg outlined the nature of engagement undertaken, context and background as well as proposed governance arrangements. ICB considered these elements of the programme.

ICB agreed the scale of ambition of the strategy needs to be increased if the system is to achieve the level of change required. The strategy should set out a plan for building an environment to enable self care with a broad focus including health, social care, carers, employer responsibilities, VCS, sustainability, advocacy etc. Self care should be embedded in all programmes with the self care programme itself being about the enablers, for example via links to the New Deal conversation. Clarity is required in terms of outcomes, achievement and performance, accepting the need to be clear on achieving some specifics and not being too general. It was acknowledged there is already a lot of work happening, for example via technology, which should be reflected more as well as describing our future focus.

ICB supports one strategy across the patch with alignment of plans to this. It was noted that resource would be via the programme but managed within adult social care. Further discussion will be needed to agree governance arrangements, informed by a re-scoped strategy.

ACTION:

- Agreed one strategy for the system with an increased scale of ambition, broader than medical focus, linked in to New Deal which aims to build an environment to enable self care. Agree governance once scope defined.

6. UPDATE ON PLANNED CARE PROGRAMME SCOPE

Clare Smart took the group through a proposed programme plan for planned care, including specific strands of focus such as physical health and in-hospital care. This has been developed on the basis of an early mandate from ICB described in the local 5YFV. Currently the proposal is for Bradford but will be developed to incorporate all that Airedale is doing already.

In the context of exploring new models of care and recent ICB discussions it was agreed the programme needs to be much more ambitious and reflective of current thinking. A broader scope is required which aligns with where we are moving towards. Although smaller specifics will be a part of the programme and represent steps along the way the overall vision must reflect the end state we want to achieve and it must be put in the context of our ambition around new models of care, additionally it must explore the relationship with urgent care and outpatients will be pivotal, plus enhanced recovery as there is good evidence around this - at scale and with good outcomes.

Leadership for this programme is yet to be agreed. Planned care is the daily business of providers and lots of work around pathway development has been undertaken, as such the approach would benefit from leadership from those organisations. Therefore, Clive Kay and Bridget Fletcher agreed to take on the ICB lead SRO role jointly and to work with Clare, Michelle Turner and colleagues to develop a scaled up, ambitious plan for Bradford and Airedale for consideration at a future ICB. Further discussion about resource and support for this programme will be undertaken when a revised programme proposal is brought to the meeting.

Discussion took place re linkage of Mental Health across the total portfolio. It was agreed that it is difficult to site responsibility with any one programme given the inherent co-dependencies and cross-cutting nature. Andrew Messina will work with Simon Large and colleagues to scope what a dedicated Mental Health Programme may look like for consideration at February ICB. Should a decision be taken to develop a Mental Health programme all other programmes will still be required to demonstrate how they are responding in terms of mental health e.g. parity of esteem.

ACTION:

- Scale of programme mandate to be broadened, in line with ICB discussions, and supported by joint SROs (Clive Kay/Bridget Fletcher). To be shared at a future ICB meeting including identified resource and support for delivery and governance arrangements.
- Agreed to scope out a MH programme to return to ICB in Feb 15 as part of the inter-programme co-dependencies work. Acknowledge all other programmes will be required to demonstrate how they are responding in terms of MH.

7. END STATE DELIVERY SYSTEM – UPDATE FOLLOWING SUB GROUP (11.12.14)

Simon Large fed back to the group about discussions from the last sub group meeting which took place on 11 Dec. The delivery models slides which were updated following discussion at the last full ICB meeting were re-circulated. At the meeting Greg Fell shared evidence gleaned nationally and internationally on new models and how successfully they have been implemented. This was mainly work around an ACO-type model of working. The group went on to consider the financial elements of an ACO-type model, mechanisms for contracting and risk/gain share. There was also discussion around the model for providers in terms of the prime contractor model or sustaining a network of providers.

The group has reached a point of consensus that changes are about population health and not just provision and that if it is concluded a new model of care is the answer then that new model should be an integrated one with appropriate governance. There remains a question as to whether a new model of care is needed and more thought will be given as to what could be achieved through transformation of the current system i.e. a new organisational delivery model, for example, changing payment mechanism, incentives etc. There are different options regarding scope of services e.g. including all or combining some; also options for a pathway approach or population approach. We are as yet unclear on the evaluation of current models and any future model - (this bullet in the slide pack needs amending for accuracy – pg 18).

The sub group considered a proposal from NHS England to take part as one of six economies in national work exploring new models of care. This is work being undertaken in conjunction with PwC and supported by Mike Farrar. The ICB is clear that if the Bradford district takes part then communications will need to be clear that it is on the basis that our economy has not yet reached consensus on a defined model that would work best for our area. There is a workshop taking place on 6th January to consider this work and the ICB

agreed to attend with a small group of delegates and feedback to ICB to agree whether this is something we would wish to continue to take part in. The ICB was clear that this is incumbent on developing a clear shared narrative/communication for local stakeholders as well as beyond (see item 3 action). Consideration will need to be taken of any wider system impact, the relationship and synergy between the directions Bradford and Airedale are moving, and social care/public health elements. The group also recognised the benefits which may arise from being part of the work such as resource to move at pace and potentially double run as well as national expertise.

It was agreed that the sub group would discuss the recent Dalton review at their meeting in January. Bridget Fletcher will circulate the summary slides published. Slides presented by Greg Fell at the 11 Dec meeting will also be circulated for information to all ICB members.

ACTION:

- Sign up to explore co-production of new models of care attending workshop on 6 Jan. Source details and share with Sub Group as system reps at the meeting. (Incumbent on shared communication being developed based on co-production of new models of care with NHSE – see action 3a, 2nd bullet)
- Amend bullet point pg 18
- Circulate Dalton review slides to support discussion at Sub Group (consider at end January ICB sub group - impact on end state delivery models)
- Circulate Greg Fell slides from 11 Dec

8. ICB FORWARD PLAN

It was agreed the LA budget proposals would be put on the agenda for the next meeting.

ACTION:

- LA budget proposals on agenda in January 15

9. KEY COMMUNICATION POINTS

None shared.

ICB plan for communications was discussed under items 3 and 7.

10. ANY OTHER BUSINESS

None put forward.

11. NEXT MEETING

Friday 16th January 2015, 9am – 12noon, Douglas Mill Room 1:1

Key Meeting Actions – Friday 19th December 2014

Action	Lead	Deadline
2. Minutes of the last meeting and action notes – to amend as below • amendment to minor typographical error pg2 • ensure minutes and action notes consistently state Feb 15 as the deadline date for taking Urgent and Emergency Care Strategy through individual organisations governance processes	Kristina Juryta	Jan 15
3a. Risk Register • Development to continue in terms of mechanism for progressing work including explicit reference to resource to support delivery of each line. For discussion at February ICB • Development of consistent narrative on work of the ICB, reasoning behind decision making and intentions going forward, adaptable for use internally, externally, locally and nationally. Fast turnaround required. (linked to item 7)	Andrew Messina Sub Group	Feb 15 Dec 14
3b. 2 things to tell • Visit to Airedale as part of Oliver Wyman work to discuss how the model worked in the USA. Bradford CCGs clinical board members to be invited to attend 13th Jan workshop • Establish linkages within system wide workforce strategy – commitment from partner organisations to input to development of a "promoting positive Bradford" via work being led by Michael Jameson	Sue Pitkethly contact Liz Allen/ Ali Jan Haider Michael Jameson/Juliette Greenwood	Dec 14 Ongoing
4. Better for Bradford Metrics – ability to measure impacts • Future iterations of the report to cover wider breadth and depth of data, informed by discussions about each programme and agreement on what metrics will provide ICB with assurance. Include summary analysis narrative describing "what this means" and historical data for context. • ICB to be sited on performance on a monthly basis, with discussion on the agenda on a quarterly basis. • Discussion re system wide analytics to feed into Feb ICB discussions, including resource need.	Cath Doman / Andrew Messina Cath Doman / Andrew Messina Andrew Messina	Jan 15 Jan 15 Feb 15

• Ensure metrics in the report are based on current BCF plan	Cath Doman	Jan 15
5. Self Care programme • Agreed one strategy for the system with an increased scale of ambition, broader than medical focus, linked in to New Deal which aims to build an environment to enable self care. Agree governance once scope defined.	Anita Parkin/ Greg Fell	TBA
6. Planned Care programme • Scale of programme mandate to be broadened, in line with ICB discussions, and supported by joint SROs (Clive Kay/Bridget Fletcher). To be shared at a future ICB meeting including identified resource and support for delivery and governance arrangements. Discussion took place re linkage of Mental Health across total portfolio: • Agreed to scope out a MH programme to return to ICB in Feb 15 as part of the inter-programme co-dependencies work. Acknowledge all other programmes will be required to demonstrate how they are responding in terms of MH.	Clive Kay/Bridget Fletcher/Michelle Turner /Clare Smart Andrew Messina / Simon Large	TBA Feb 15
7. End State Delivery System National new models of care work (NHSE/Farrar/PwC) • Sign up to explore co-production of new models of care attending workshop on 6 Jan. Source details and share with Sub Group as system reps at the meeting. (Incumbent on shared communication being developed based on co-production of new models of care with NHSE – see action 3a, 2nd bullet) • Amend bullet point pg 18 • Circulate Dalton review slides to support discussion at Sub Group (consider at end January ICB sub group - impact on end state delivery models) • Circulate Greg Fell slides from 11 Dec	Kristina Juryta ICB Sub Group Damien Kay Bridget Fletcher ICB Sub Group Damien Kay	Dec 14 Dec-Jan 15 Dec 14 Dec 14 Jan 15 Dec 14
8. ICB Forward Plan • LA budget proposals on agenda in January	Janice Simpson/ Michael Jameson /Anita Parkin	Jan 15