Meeting: **Locality Board**			
Meeting Date	05 June 2023	**Action**	Receive
Item No.	6	**Confidential**	No
Title	Integrated Delivery Collaborative Update		
Presented By	Kath Wynne-Jones, Chief Officer, IDC		
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Executive Summary

This paper is intended to provide an update to the Locality Board of progress with the next stage of the development programme for the IDC and progress with the delivery of programmes across the Borough

Recommendations

The Locality Board is asked to note the progress with the development plan of the IDC and progress of the programmes and consider the next steps outlined within the paper.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☒	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
Once achieved, the ambition of the IDC will have a positive impact on the quadruple aim domains of population health ,experience, workforce and economics						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
IDC Board	24/05/2023	Proposal supported, recognising there are risks with making further commitments to reduce demand

Bury Integrated Delivery Collaborative Update

1. Context

This report is intended to outline to the Board progress which has been made with the key issues relating to the implementation of the IDC development plan, approved by the Board in March 2023.

2. Programme structures

As a reminder, programme leadership arrangements for locality programmes of care, enabler programmes and quadruple aim objectives are outlined below:-

System Committees / Subgroups	**SRO / Managerial Leadership**	**Clinical /Professional Leadership**
Clinical and Professional Senate	Kiran Patel / Cathy Fines	Kiran Patel / Cathy Fines
GP Collaborative	Mark Beesley	Kiran Patel / Cathy Fines
Strategic Estates Group: Health and Care subgroup	Paul Lakin / Catherine Wilkinson	No direct input – connection via senate
Digital Board	Andrew Carter/ Kate Waterhouse	Sanjay Kotegaonkar
Communications and Engagement Cell	Karen Johnston	No direct input – connection via senate
Strategic Finance Group	Sam Evans	No direct input – connection via senate
Population Health Delivery Board	Jon Hobday	Jon Hobday
Strategic Workforce Group	Kat Sowden	No direct input – connection via senate
System Assurance Committee	Catherine Jackson	Catherine Jackson
Primary Care Commissioning Committee	Will Blandamer	Cathy Fines
Programmes		
Urgent Care	Jo Fawcus	Kiran Patel
Elective Care and Cancer	Karen Richardson - interim	Wendy Craven / Simon Minkoff/ Leanne Harris
Adult Social Care	Adrian Crook	Adrian Crook
Mental Health	Donan Kelly	TBC
Learning Disabilities	Adrian Crook	Nigget Saleem
Complex Care	Catherine Jackson	Catherine Jackson
Neighbourhood Delivery	Ian Trafford – interim	Neighbourhood lead GP's and INT leads
Primary Care	Mark Beesley	Kiran Patel/ Cathy Fines

Community services transformation	Nina Parekh	Neighbourhood lead GP's and INT leads
Ageing Well (including frailty and dementia)	Frailty -Katy Alcock Dementia - TBC Ageing well at home – TBC	? NCA
End of Life and Palliative Care	Helen Lockwood/ David Thorpe	Richard Deakin
LTC (CHD, respiratory and diabetes)	TBC	Finn McCaul

As members may be aware, we reorganised programmes of change last year to try and reduce and streamline the number of programmes of change, directing those which connect more directly into neighbourhood working into the neighbourhood delivery group. However, this arrangement has proved unsuccessful, with other programme boards still remaining, therefore appendix 1 outlines the establishment of the following Boards reporting to the IDC Board.

- Urgent care
- Elective Care and Cancer
- Mental Health
- Learning Disabilities
- Complex Care
- Adult Social Care
- Palliative Care and End of Life
- Community Services Transformation
- Primary Care (via GP Collaborative)
- Ageing Well (including frailty , dementia and ageing well at home)
- Long Term Conditions

This approach sees the formal creation of an ageing well board to encompass aging well at home, frailty and dementia, and the creation of a long term conditions board to enable approaches to the management of LTC to be coordinated. This is also felt to be desirable to support clinical engagement across organisational boundaries

The new arrangement will negate the need for the Neighbourhood Delivery Board and NCAG as separate groups. We have tried to minimise the infrastructure required in the locality as much as possible , however it is felt that the above arrangements are required to deliver programmes of change that meet local, GM and national requirements in a coordinated yet manageable way.

Connectivity and communication between the SRO's will be key to ensure alignment and to reduce silo working. It is proposed that this is supported through regular workshops for SRO's. The first of these was held on the 16th May.

3. Programme leadership

Work has continued to mobilise new arrangements for programme leadership with SRO's, and to identify capacity available to support the various programmes of change. An initial draft of current resource aligned to programmes for former CCG commissioning colleagues, former LCO colleagues and BMBC commissioning teams has been prepared. This will be finalised next week and shared with the Board and SRO's w/c 30th May, with a request to identify any provider-based change resource which could also be aligned to programmes to support delivery.

Clinical leadership discussions are continuing between the locality and GM to understand the arrangements which will need to be put in place to support the differing geographical footprints, to support the GM programmes of cancer, paediatrics, urgent and emergency care, primary care, mental health/LD/autism & long-term conditions.

A workshop was held for SRO's and Clinical Directors on the 16th May which had good attendance and good engagement in the discussions.

The session objectives were:

- To enable our system leaders to come together in a collaborative space for development work providing opportunities for relationship/trust building and the formation of a peer network of system leaders.
- To develop a shared understanding of the current strategic context/locality landscape (including governance structures) in which our system leaders operate.
- To determine the role requirements for the SRO/Clinical Leadership role covering both transformation and enabler programmes.
- To provide an approach/framework for system leaders to support the establishment of the programme infrastructure.
- To provide clarity on the current asks of SROs, including undertaking baseline assessments, development of priorities and associated metrics for each programme.
- To start to identify what support looks like for our system leaders.

The session served to:

Confirm that role outlines (SRO/Clinical Leader) are in line with understanding/expectations for role. However, key feedback from the group was requesting clarity regarding the levels of accountability/decision making in the role, and recognition of the capacity and complexity challenges, with a clear need identified for delivery support roles.

SROs agreed to undertake their baseline assessment using the maturity matrix, identify their 3 (ideally) key priorities and associated metrics for improvement, to then regroup on the 5th July to understand ambitions of programmes and determine our key priority areas.

To ensure coherence of delivery, and to enable a robust discussion regarding the prioritisation of where we direct our transformation resource, it is proposed that each of the programmes undertakes an initial baseline assessment against the domains of :

- System integration
- Key programme characteristics
- Programme maturity

System integration	Key programme characteristics	Programme maturity
Leadership	Description of purpose	Programme Board
Governance	Description of connectivity into neighbourhood delivery	Key priorities and milestones agreed
Culture	Adopt strength based /asset based approaches	Key provider engagement (including the VCFA)
Service user and carer engagement	Connectivity into GM programmes	Clinical and professional leadership
Financial and contractual mechanisms	Prevention and early intervention	Defined metrics against each of the quadruple aim objectives • population health and reducing inequalities • effectiveness • efficiency • workforce
Information and IT		Risk register in place
Workforce		Adequate programme support
Service and care model design		

There was a strong feeling in the room that whilst all programmes will need to report to the IDC Board to enable an holistic view of the system to be taken, we may wish to direct our dedicated transformation capacity to a small number of priorities which will have the biggest impact on outcomes.

As an IDC Board we still need to determine the weight of importance we will give the quadruple aims of:

- Population health
- Efficiency
- Outcomes and Effectiveness
- Workforce

This will be considered by quadruple aim leads over the coming weeks

4. May IDC Board update

Programme highlights:

Elective Care: Cardiology Advice and Guidance now live
End of Life and Palliative Care: Preparation for the summit on the 28th June and delivery of events to mark Dying Matters week

Urgent Care: Had the highest volume of patients receiving care on the virtual ward at one time. 19 patients were receiving care at any one time against our trajectory of 20
Mental Health: Sustained improvement in IAPT waiting times with progress being made on the design and delivery of the Living Well and CMHT models
Adult Social Care: 14-25 Programme Board established
Complex Care: April performance at 79% with no long waits or reviews waiting more than 3 months
Neighbourhood development: East have been leading and participating in events to mark national bowel screening month linked to their neighbourhood development priority
Community Services: Scoping work commenced to support the development of a rehabilitation hub and to rationalise single points of entry to the system across the Borough
Primary Care: Project Initiation Document developed for a women's health hub and to develop back office functions. Practice Nurse Forum relaunched on the 30th May

Board meeting summary: 24th May

1) Received an update from the Chief Officer on the work to support all of 11 programmes to identify key priorities and ambitions as outlined above. The Board will need to consider over the next month the weighting given to the domains of economics, population health, workforce and quality when prioritising where to target our limited transformation resources

2) Received an update on work to establish a system risk register as outlined below. The Board understands the obligation of each individual organisation to maintain its own risk register, but we meet as a partnership in recognition of the consequences of our actions on each and because of the opportunity to improve outcomes for our residents by working together more effectively. In this spirit, a shared understanding of common risks helps us to prioritise our work

3) Approved the paper which has been received by the Locality Board as a separate item by the Locality Board outlining trajectories submitted to the ICB for reducing growth and demand for some secondary care services in urgent and elective care.

4) The meeting then received a number of 'deep dive' presentations into 4 of the delivery programmes:
    a. Mental Health Programme – the established programme board is now producing and developing a implementation plan addressing national and locally derived priorities. There has been a focus on securing investment in mental health service provision, to increase mental health capacity to the neighbourhood teams. Discussion focused on the reality of mental health crisis resolution around the Emergency Department, and the need to focus on transitions. Further work will be undertaken regarding these 2 topics
    b. The graduated approach in SEND – health partners in the borough were briefed on this important development focusing on the shift from a medical to social model. Further opportunities for briefing all key partners, such as via the GP webinar are being progressed.
    c. Urgent Care – the Board received an update on the performance of the urgent care system which, while very challenged, has performed relatively well. The Board considered key next priorities for reform, which will be considered at a workshop on the 12th June. The meeting also received an update on the specific steps taken to

improve our “Days Kept Away from Home” numbers at FGH connecting to the NCA discharge frontrunner programme

d. Primary care programme– the Board was briefed on the implications for partners in the system of new responsibilities for GPs under ‘recovering access to GPs’ guidance issued on 9th May . Areas of focus are empowering patients, modernising GP services, building capacity and cutting bureaucracy.The priorities are
    1. To tackle the 8am rush and reduce the number of people struggling to contact their practice. Patients should no longer be asked to call back another day to book an appointment
    2. For patients to know on the day they contact their practice how their request will be managed within the next 2 weeks

5) The Board was briefed on the work of the communications leads from partners in the system to work together more effectively, and to note the establishment of the Bury Integrated Care Partnership website.

5. Risks

Following agreement of the proposed Bury system risk reporting process at April’s IDC Board, all programmes and relevant committees were asked to submit any risks of 12+ using the GM risk reporting template. It was recognised that due to the tight reporting deadline it may not be possible, in all cases, for programmes to obtain sign off from the relevant board of the risks to be escalated to IDCB.

From the first reports submitted, it is recognised that there is a need to issue some further guidance and provide further support with regard to risk scoring to ensure consistency of approach.

Over the next month we will follow up with all Chairs the need for the risk report which has been approved through their governance arrangements. As an IDC Board we are considering how we structure our discussions to enable robust risk management on behalf of the Locality Board.

6. Recommendations

The Board are asked to note the progress with the development plan of the IDC, core programmes and consider the next steps outlined within the paper

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Appendix 1

BURY INTEGRATED CARE PARTNERSHIP

Bury Integrated Care Partnership – Partnership Arrangements