Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Partnership Meeting

Agenda

Date/ Time: Thursday 21 March 2024, 09.30 - 11.30
Location: Council Chamber, Oxfordshire County Council, New Road, Oxford, OX1 1ND / Hybrid

	Timing	Item	Action	Lead
1.	**0930**	**Welcome and Introductions**	Information	Chair
2.		**Apologies for absence and temporary appointments**	Information	
3.		**Declarations of Interest**	Assurance	
4.		**Minutes from the meeting held on 24.01.2024**	Approval	
5.	**0935**	**Confirmation of Any other business**	Approval	Catherine Mountford, ICP Secretariat
6.	**0935**	**Petitions and Public Address**	Discussion	Chair
	Delivering the Strategy			
7.	**0940**	1. **Delivering in place** – Oxfordshire Health and Wellbeing Strategy 2. **System planning, transformation and recovery**	Discussion	1) Cllr Liz Leffman, Health and Wellbeing Board Chair 2) ICB to present
	Governance			
8.	**1030**	**Ways of working** – Includes write up from January workshop discussion**.**	Discussion	Catherine Mountford, ICP Secretariat
9.	**1100**	**Forward Plan**	Discussion	Catherine Mountford, ICP Secretariat
10.	**1105**	**Any Other Business** (Notified in advance) - ICB Chair Appointment - ICB/NHS financial position and implications - Work Well proposals - Update on LA funding/plans for 2024/25	Discussion	Chair
	1130	**END**		

Dates of future meetings:	
Wed 19 June 2024, 1-3pm public; 2-5pm workshop	September Onwards – TBC

Please send apologies to the ICP secretariat Email: bobicb.corporatecalendar@nhs.net

ICP members

Member category	Named member
Buckinghamshire Council	Cllr Angela Macpherson (ICP Deputy Chair) Cllr Zahir Mohammed Cllr Martin Tett
Oxfordshire County local authorities (County and district councils)	Cllr Tim Bearder Cllr Liz Leffman Cllr David Rouane
Reading Borough Council	Cllr Jason Brock (ICP Chair)
West Berkshire Council	Cllr Alan Macro
Wokingham Borough Council	Cllr David Hare
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board	Sim Scavazza, Acting Chair
Representative from an acute NHS provider	Professor Sir Jonathan Montgomery, Chair, Oxford University Hospitals NHS FT
Representative from a mental health NHS foundation trust	Martin Earwicker, Chair, Berkshire Healthcare NHS FT
Representative from the South Central Ambulance Service NHS Foundation Trust	Professor Sir Keith Willett CBE, Chair
Two representatives from primary care; one to be a GP	Laurie Powell, Dentist, Oxfordshire Dr Martin Thornton, GP, Buckinghamshire
Directors of Public Health for each place/LA	Dr Jane O'Grady (Buckinghamshire) Ansaf Azhar (Oxfordshire) John Ashton (Reading and West Berkshire) Ingrid Slade (Wokingham)
Representative from Healthwatch	Sylvia Buckingham, Trustee, Oxfordshire Healthwatch
Representative from the BOB VCSE Alliance	William Butler, Chair
Representative from Health Innovation Oxford and Thames Valley (formerly Oxford Academic Health Sciences Network)	Professor Gary Ford CBE, Chief Executive
Representative from care sector providers	TBD
Representative of child and adolescent mental health	Nicola Leavesley, Chief Executive, Response
ICB Chief Executive Officer	Dr Nick Broughton
One Director of Adult Social Services (DASS	TBD
One Director of Children's Services (DCS)	TBD

Minutes

ICP – Meeting in Public

Wednesday 16 January November 2023, 1300 – 1506

Hybrid – Buckinghamshire Council / Microsoft Teams

Members	Organisation	Attendance
Cllr Jason Brock	**ICP Chair**; Reading Borough Council	Apologies
Cllr Angela Macpherson	**ICP Deputy Chair**; Buckinghamshire Council	Attended – Physically
John Ashton	Reading Council	Apologies
Ansaf Azhar	Oxfordshire County Council	Apologies
Cllr Tim Bearder	Oxfordshire County Council	Apologies
Nick Broughton	BOB ICB	Attended – Physically
William Butler	BOB VCSE Health Alliance	Attended – Physically
Martin Earwicker	Berkshire Healthcare NHS Foundation Trust	Attended – Virtually
Professor Gary Ford CBE	Health Innovation Oxford & Thames Valley (formerly Oxford Academic Health Sciences Network)	Apologies
Cllr David Hare	Wokingham Borough Council	Attended – Virtually
Nicola Leavesley	Response	Attended – Physically
Cllr Liz Leffman	Oxfordshire County Council	Attended – Virtually
Cllr Alan Macro	West Berkshire Council	Attended – Virtually
Prof Sir Jonathan Montgomery	Oxford University Hospitals NHS Foundation Trust	Apologies
Dr Jane O'Grady	Buckinghamshire Council	Attended – Physically
Don O'Neal	Oxfordshire Healthwatch	Apologies – Delegated below
↳ Sylvia Buckingham	↳ Oxfordshire Healthwatch	Attended – Virtually
Laurie Powell	Primary Pharmacy, Optometry & Dentistry (POD) Services	Attended – Physically
Cllr David Rouane	South Oxfordshire District Council	Attended – Virtually
Sim Scavazza	BOB ICB	Attended – Physically
Ingrid Slade	West Berkshire Council	Attended – Virtually
Cllr Martin Tett	Buckinghamshire Council	Attended – Physically
Prof Sir Keith Willett CBE	South Central Ambulance Service NHS Foundation Trust	Attended – Physically
Dr Martin Thornton	Primary Medical (GP) Services	Attended – Virtually
Cllr Zahir Mohammed	Buckinghamshire Council	Apologies
Attendees		
Rachael de Caux	BOB ICB	Attended – Item 7 – Physically
Dr Abid Irfan	BOB ICB	Attended – Item 7 – Virtually
Louise Smith	BOB ICB	Attended – Item 7 – Physically
James Robinson	Buckinghamshire Council	Attended – Item 8 – Physically
Isabel Rockingham	Oxfordshire County Council/ BOB ICB	Attended – Item 9 – Virtually
Hannah Iqbal	BOB ICB	Attended – Physically
Catherine Mountford	ICP Secretariat; BOB ICB	Attended – Physically
Amaan Qureshi	ICP Secretariat; BOB ICB	Attended – Physically

2 members of the public attended in person and 13 virtually.

Board Business		
1.	**Welcome and Introductions** The ICP Deputy Chair (Angela Macpherson) (henceforth referred to as 'Chair' for the purpose of today's meeting) announced that Chair Jason Brock sends his apologies. The Chair opened the hybrid meeting and conveyed her thanks to the Integrated Care Partnership (ICP) membership and public for attending.	
2.	**Apologies for absence** Apologies as above.	
3.	**Declarations of interest** None noted.	

4.	**Minutes from the meeting held on 22 November 2023** The minutes from the meeting of 22 November 2023 were agreed as a correct record, with one minor spelling correction noted.	
5.	**Confirmation of Any Other Business** No business was received in advance or raised for inclusion under Any Other Business (Item 11).	
6.	**Petitions and Public Address** None received in advance for this ICP meeting.	
7.	**Deep Dive Topic – Draft Primary Care Strategy** Rachael De Caux (Chief Medical Officer; Deputy Chief Executive Officer, BOB ICB) presented Item 7, the Primary Care Strategy, which is the comprehensive plan for the system's Primary Care, with a focus on improving access, integrating services, and addressing health inequalities in the system. BOB ICB welcomed the feedback and discussion from ICP members around the Primary Care strategy. The following was presented and discussed: • Thanks were noted to all system partners for their engagement in the development process of the strategy. A longer period of engagement has been fruitful to help nuance and shape the draft strategy. • The strategy is centred around three main priorities: same-day non-complex care, integrated neighbourhood teams, and cardiovascular disease prevention. It highlights the importance of digital tools, workforce development, and effective estates utilisation as key enablers for its delivery. Implementation will be key, particularly around effective resource allocation, the role of community services such as pharmacies, and the state of primary care buildings. • It was developed with ongoing engagement with key system stakeholders, including Healthwatches and local authorities, to ensure it meets the needs of the local population and addresses the challenges faced by the primary care sector. • Investment needs to align with the priorities of the strategy. Members discussed the need to consider what we might have to stop doing, and to be open about it, in implementation. • The capacity of community pharmacies and dentistry to handle additional workload should be considered, given existing challenges they face. • The strategy implies a shift of resources into the primary care sector. While this makes sense in the long term, it was noted that the benefits from changes to primary care may not immediately result in reductions in hospital workloads. Resources need to be shifted not just away from the acute sector and into community and primary care services, but also into more deprived areas. • The state of primary care buildings being fit for purpose was raised as a concern, and that whilst the strategy acknowledges the challenges around estates, it needs to be clearer on the solutions. • The strategy proposes alterations in work patterns and the management of funds. The implications of these changes on the actual execution of the strategy remain should be clearer. • Definitions and language within the strategy should be more clearly defined – for example, the strategy mentions a lot of teams (action teams, neighbourhood teams, place delivery teams) but it isn't always clear what these teams are or what they do. • Care will transform to be more towards self-management with the smarter use of triage tools. There will be a shift towards a more community-based model of care, with residents at the heart of it. Consideration must be given to the resources being available to enable this, with consideration to how this will work inclusively in practise, particularly for older people who may not be comfortable with digital tools. • Implementation will follow a phased approach, focusing on a small number of high-impact actions. Concerns around the workforce capacity to implement these changes were discussed. • The strategy's focus on GP access was noted, with other aspects of primary care, such as dentistry, also needing attention. The importance of access to dental care was highlighted, with concerns raised about a 19% reduction in people's ability to get an appointment. Emphasis was given for the need for a plan to recruit and retain dentists in the NHS. • It was suggested the strategy should consider the impact it may have on GP working patterns, for example it may lead to GPs working at the top of their licence, focusing on managing patients with multiple long-term conditions. • If related workforce considerations are not addressed, GP shortages may continue to impact the resident experience.	

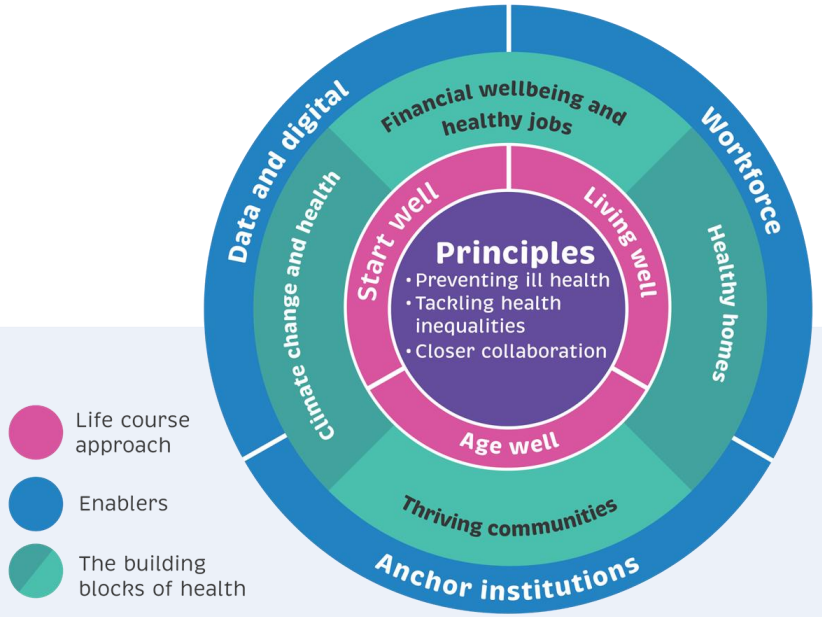
	• The strategy's potential to reduce health inequalities was discussed. It was suggested that resources need to be allocated where they are most needed, in the most deprived areas. • The strategy's potential to change the way primary care services are situated was discussed. Important we look at how health can devolve beyond just GPs, to touchpoints within the broader system – for example during visits to local partners, businesses, etc. • It was suggested that primary care services could utilise spare capacity within council buildings for the provision of some services, and other estates such as fire stations, police stations, or schools, as part of the 'one public estate' agenda. • A slow-burn shift in GPs moving to private is something to be mindful of. We need to consider all the additional 'draw factors' which BOB can offer GPs above and beyond pay – because pay alone isn't the key motivator/driver for retention of GPs. • The importance of clear communication was stressed including use of layman's language in the strategy as some of it was difficult to understand if you were not a health professional. This needed to cover provision of clear information to residents about the different clinical professional they may see in primary care and how to access services including sue of the NHS App.	
8.	**Delivering the Strategy** **8.1 <u>Delivering in place – Buckinghamshire Health and Wellbeing Strategy</u>** Angela Macpherson (Meeting Chair; Deputy Leader, Buckinghamshire Council) presented Item 8.1, the Buckinghamshire Health & Wellbeing Strategy. The strategy is a comprehensive plan that focuses on improving health outcomes and reducing inequalities, particularly in the 10 most challenged wards in Buckinghamshire, under a programme called Opportunity Bucks. The strategy is divided into three themes: starting well, living well, and aging well, each with specific priorities. The following was presented and discussed: • A new online performance dashboard was demonstrated to members. This has been developed to monitor the delivery of the strategy programme. The dashboard displays key indicators related to the strategic priorities and provides context and data analysis. The dashboard is publicly available on the Buckinghamshire Council website here and is updated quarterly to align with the health and well-being board meetings. • The meeting discussed the importance of transparency and public understanding of the issues being addressed. There were questions about the accessibility of the information presented in the dashboard and how many people are accessing it. • Members discussed the need to focus on the longer-term aims of utilising the data, and how it can be used to effect meaningful impact on better outcomes. • The meeting concluded with an acknowledgment of the significant amount of work that has gone into the development of the strategy and the dashboard, and a commitment to continue focusing on these priorities. **8.2 <u>System Goals January update</u>** Hannah Iqbal (Chief Strategy & Partnerships Officer, BOB ICB) presented an update on system goals, which were initially presented in November. The update focused on refining the goals to address the system's resource constraints and to ensure all system partners play their part in delivering these goals. The following was presented and discussed: • The initial plan had 13 goals for the system to prioritise. However, feedback from system partners, including the ICP, suggested reducing the number of goals, addressing financial constraints, and considering system resources in their entirety. The revised plan identifies six programmes of work where collaboration across the system could add value. These programmes involve pooling resources across different NHS providers, local government partners, and the voluntary sector. • The programmes address significant issues within the population, such as cardiovascular disease and children and young people's mental health. • The next step is to gather feedback, finalise the goals, and plan to report on delivery from March. • The resource constraints of the system were discussed and the need for all system partners to play their part in delivering these goals. • The role of education in the partnership was suggested as an area which needs more focus, with the potential for schools to contribute to health education. Schools are one of the largest estates we have in the region – there's underutilised capacity after school hours. • Prevention was acknowledged as key, underpinning all the goals.	

	• There was a question about clarifying the relationship between the agenda of the ICP and the ICB, and how the two bodies work together to improve the overall health of the population they serve – and how this might not always be clear to the public. **The meeting concluded with the agreement that the updated system goals will inform the final set of proposals that will be presented to the ICB Board in March.**	
9.	**BOB proposals for Accelerating Reform Fund** Isabel Rockingham (Commissioning Manager, Joint Commissioning team, Oxfordshire County Council/BOB ICB) presented Item 9, the BOB proposals for Accelerating Reform Fund. The fund is an unexpected allocation from the Department of Health and Social Care aimed at scaling and transforming adult social care. The following bullet points were presented and discussed: • The fund is expected to be around £980,000 across BOB, further broken down into each local authority area. The funding is primarily led by local authorities, but there is an expectation to work with the NHS, the voluntary sector, and unpaid carers. • The funding will be used for a mixture of projects aligned to key themes, including unpaid carers, using housing as an alternative to long-term care, and self-help and prevention. The projects are designed to improve the identification, assessment, and support of unpaid carers, expand existing services like the shared life service and home share service, and increase the capability of existing digital directories of information. • The next step is to submit more detailed project plans and a memorandum of understanding with the Department of Health and Social Care due in February. • Non-recurrent funding can carry risks, with successful programmes facing a cliff-edge at the end of the funding term. Members discussed the sustainability of the projects and the importance of leaving the service offers at a better level than when they started. • Members noted the importance of involving seldom heard communities in these projects. **The ICP noted and approved the proposals, with a caveat about the importance of sustainability of funded programmes and around managing expectations.**	
10.	**Ways of working** Catherine Mountford (ICP Secretariat; Director of Governance, BOB ICB) presented Item 10, Ways of Working, item, which focused on increasing awareness and discussing the membership terms of reference. The key points discussed were: • The secretariat will aim to produce a short briefing paper following ICP meetings to increase awareness. This paper will be widely distributed and may be useful to health and well-being boards. • There was a discussion about the representation of Directors of Public Health (DPH) on the ICP. Initially, there were three DPHs, one for each county. However, there are now four DPHs due to changes in Berkshire West, with the establishment of a DPH for Wokingham. There is a need for clarity to determine whether the intention is to have one DPH per place at ICP, or all DPHs. • The proposal is for all four DPHs to sit on the ICP. Some members expressed an openness to continue with four DPHs, however particularly with the addition of a DPH for Wokingham, there was a discussion about the balance of representation. • The clause within the Terms of Reference requiring specific geographic representation for the acute provider representative, mental health representative, and GP representative was discussed, with view to removing the geographic restrictions. Members discussed the need to maintain geographic diversity. It was suggested that no more than two representatives should come from one place. **The meeting concluded with the agreement to redraft the membership terms of reference to say the NHS representatives should be no more than 2 from one place.**	
11.	**Forward Plan** Catherine Mountford (Director of Governance, BOB ICB) presented the forward plan, which highlights items for discussion at the ICP for the meetings ahead. The plan will be updated based on the outcomes of an upcoming workshop, while will inform the forward plan themes.	
12.	**Any Other Business** (Notified in advance) There being no other business, the meeting was ended at 3.06pm.	
END		**Next Meeting: Thu 21 March 2024**

Item 07.1

Health and wellbeing strategy

Oxfordshire, 2024-2030



NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Oxford University Hospitals NHS NHS Foundation Trust

GP practices

Oxford Health NHS NHS Foundation Trust

healthwatch Oxfordshire

West Oxfordshire District Council

South Oxfordshire District Council Listening Learning Leading

Vale of White Horse District Council

Cherwell District Council North Oxfordshire

Oxford City Council

Oxfordshire County Council

How we got here

Oxfordshire's Health and Wellbeing Board: Health and Wellbeing Strategy in 2019

Covid-19 pandemic

Cost of living crisis

Health and Care Act 2022: Integrated Care Systems

BOB ICS Strategy

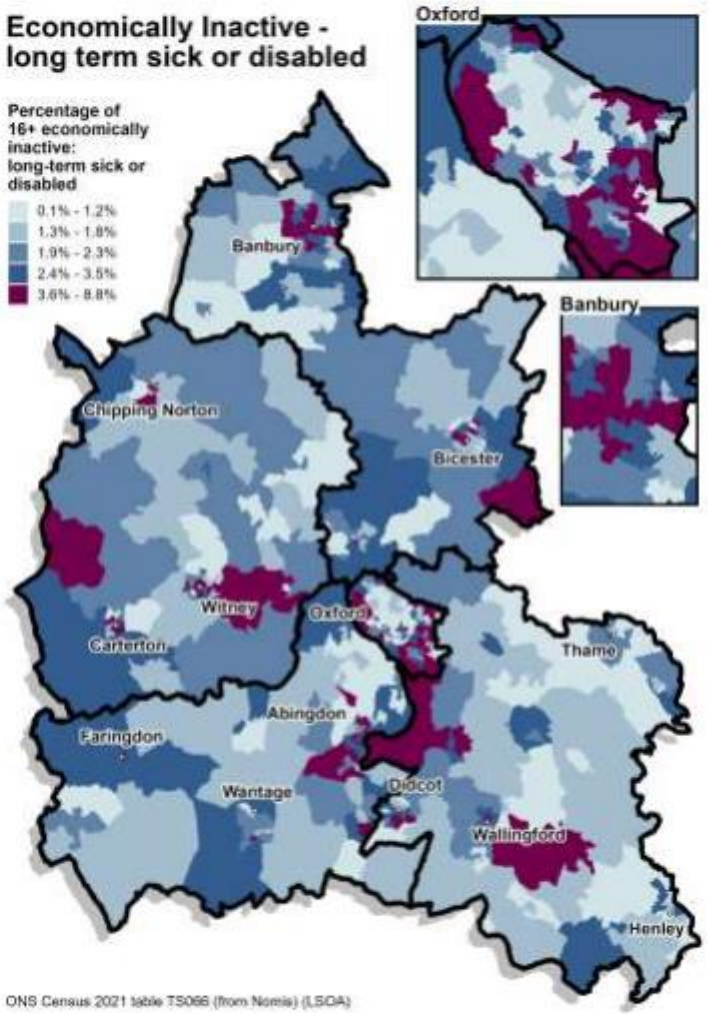
NHS Joint Forward Plan

JSNA 2023

Oxfordshire Health and Wellbeing Strategy 2024-2030

Economically Inactive: long term sick or disabled

- The Census 2021 asked residents to answer questions on their economic activity status. People aged 16 years and over were economically inactive if, in the week before Census 2021, they were not in employment, and they were:
  - not looking for work
  - looking for work, but were not able to start work in the next two weeks
- The Census 2021 shows 36% (215,938) of Oxfordshire residents aged 16 and over were economically inactive. This is below the South East (38%) and England (39%) average.
- Of those that were economically inactive in Oxfordshire, 2% (13,958) were inactive due to long term sickness or disability. This is below the England rate 4%.
- Some of the small areas that are economically inactive due to long term sickness or disability are:
  - Blackbird Leys (9%)
  - Northfield Brook (9%)
  - Banbury Grimsbury and Hightown (8%)
- These are above the South East (3%) and England (4%) average.

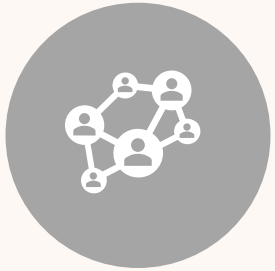


TS066 - Economic activity status

Census 2021 took place during the coronavirus (COVID-19) pandemic, a period of unparalleled and rapid change; the national lockdown, associated guidance and furlough measures will have affected the labour market topic. The economically active population includes people who were put on furlough at the time of Census 2021, who were considered to be temporarily away from work.

Public Engagement and Consultation

Reviewed **existing reports** and research which detail residents' thoughts and opinions.



13 Focus groups among residents we especially want to hear from- seldom heard communities in partnership with existing community groups and voluntary organisations.

Healthwatch Oxfordshire have surveyed >1000 residents, spoken to residents at events across the County, and hosted an online conversation with the voluntary and community sector

Formal **public and professional consultation Oct-Nov 23, >400 responses,** incorporated into final strategy and approved by HWB

5 Key Points

- **Oxfordshire's One Place Strategy**
- **Aligning with ICS**
- **A broad view of wellbeing**
- **Collaboration and prioritisation**
- **Strategy** -> delivery

Health and wellbeing strategy

Oxfordshire, 2024-2030

Principles

Preventing ill health

Tackling health inequalities

Closer collaboration

Start well

Priority 1: The best start in life

All children in Oxfordshire should experience a healthy start to life and be ready for school, especially in our most deprived communities.

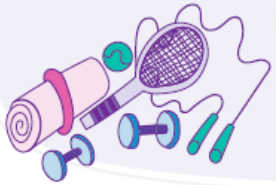
Priority 2: Children and young people's emotional wellbeing and mental health

More children and young people in Oxfordshire should experience good mental health and emotional wellbeing.

Live well

Priority 3: Healthy people and healthy places

The length and quality of people's lives in Oxfordshire should not be negatively impacted by exposure to tobacco, alcohol, or unhealthy weight. People in Oxfordshire should live in healthy environments where they can thrive free from these harms.



Priority 4: Physical activity and active travel

Residents of Oxfordshire should be able to remain active throughout their lives, especially in our most deprived areas.

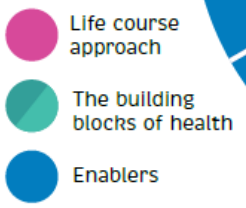
Age well

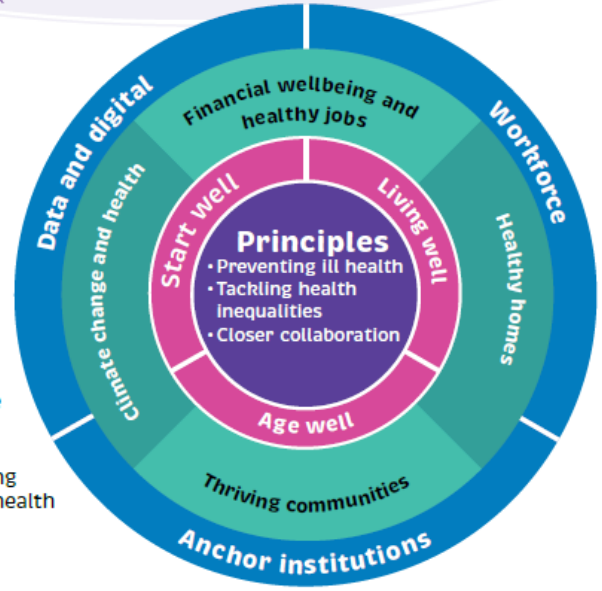
Priority 5: Maintain independence

We will support more older residents to remain independent and healthy, for longer. We will ensure they are always treated with dignity and are fully valued.

Priority 6: Strong social relationships

Everyone in Oxfordshire should be able to flourish by building, maintaining, and re-establishing strong social relationships. We want to reduce levels of loneliness and social isolation, especially in rural areas.





Health and wellbeing strategy

Oxfordshire, 2024-2030

Building blocks

Priority 7: Financial wellbeing and healthy jobs

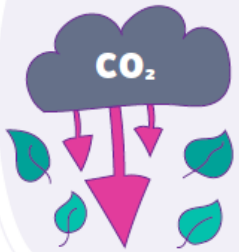
All of Oxfordshire's people should have good living standards and financial wellbeing. Our local economy should be inclusive, equitable, and fair and everyone should be able to contribute through life-long learning and good quality and stable work.

Building blocks

Priority 9: Healthy homes

Everyone should have access to quality, affordable, and energy efficient homes which support their health and wellbeing. Social, private rented, and new build homes should be of a good material standard and maintained to prevent health issues.

Building blocks



Priority 8: Climate change and health

The health and care system in Oxfordshire should take action to reduce climate change and the impacts of climate change on people's health.

Building blocks

Priority 10: Thriving communities

We will support and enable all communities to play their key role delivering better health and wellbeing for people across Oxfordshire.

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Oxford University Hospitals NHS Foundation Trust

GP practices

Oxford Health NHS Foundation Trust

healthwatch Oxfordshire

West Oxfordshire District Council

South Oxfordshire District Council

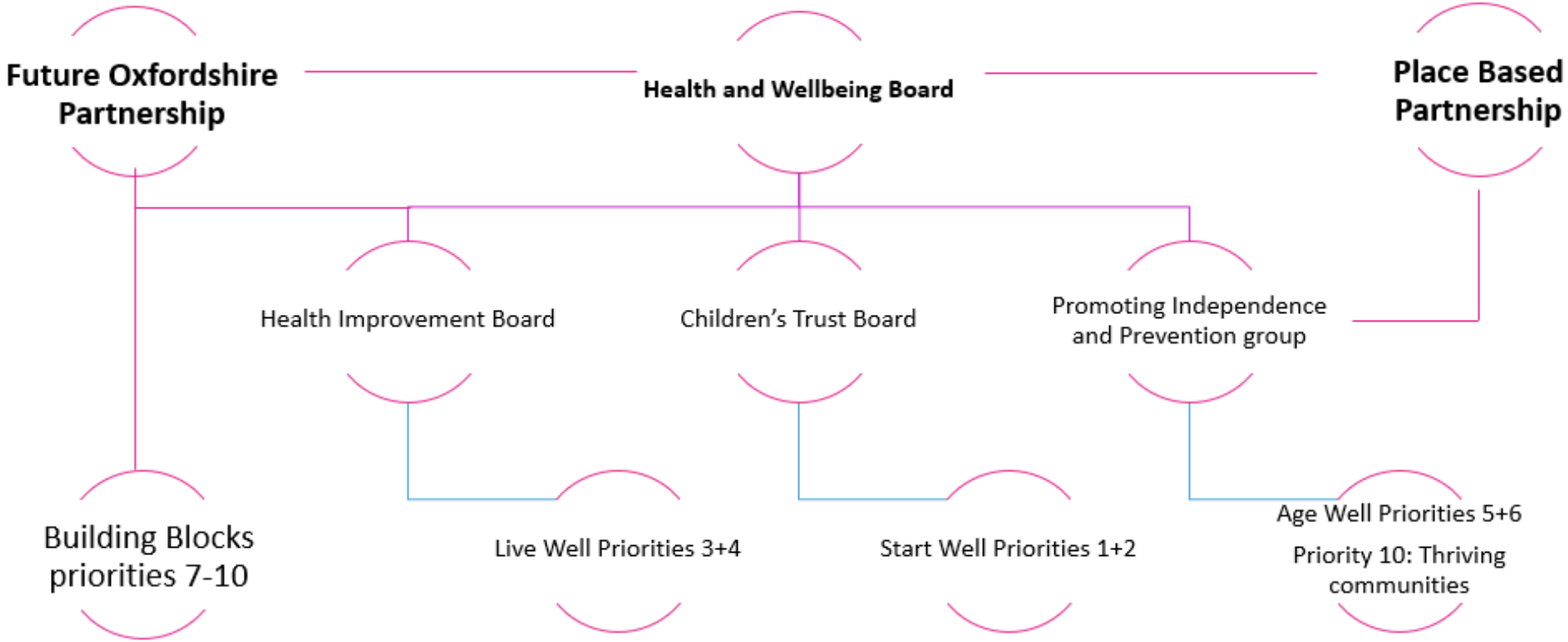
Vale of White Horse District Council

Cherwell District Council North Oxfordshire

Oxford City Council

Oxfordshire County Council

Proposed Reporting Structure



Priority 4: Physical activity and Active Travel

Residents of Oxfordshire should be able to be and stay physically active, for example by walking and cycling, especially in our most deprived areas.

Shared outcomes	Key activities delivering on priority	Key Outcome Indicators	Supporting Indicators
4.1 A system wide approach to physical activity, incorporating key physical activity programmes	Oxfordshire on the Move Move Together programme You Move programme Oxfordshire's Whole System Approach to Obesity Action Plan	Percentage of physically active adults Percentage of physically active children	Uptake of Move together/You move programmes Number of schools participating in Schools Active Programme -TBC
4.2 Whole system approach to improving access and uptake of active travel options	Oxfordshire Healthy Place Shaping Action Plan Oxfordshire Infrastructure Strategy 2021-2040 Local Plans/Neighbourhood plans Net Zero Route Map and Action Plan Local Transport and Connectivity Plan	Active travel - percentage of adults walking/cycling for travel at least three days per week (age 16+)	Number of Cycling and Walking Activation initiatives that promote inclusion - TBC *By 2030 the Route Map ambition is for a: 20% reduction in vehicle miles from personal trips. 10% mode shift of personal trips (private vehicles to sustainable modes)*
4.3 Recognition and action on the critical importance of being active for mental health and wellbeing	Oxfordshire Mental Health Prevention Framework Oxfordshire Mental Health Partnership partner programmes Oxfordshire Social Prescribing NHS Health Check Programme Making Every Contact Count programme	Self reported wellbeing: people with a low happiness score or ONS wellbeing measures of anxiety, happiness, satisfaction and worthwhile Percentage of people using outdoor space for exercise/health reasons - TBC	Adult patients recorded with a diagnosis of depression Emergency hospital admissions for intentional self-harm in all ages

Primary partnership for priority	Key Partnerships
Health Improvement Board	Active Oxfordshire Safer Oxfordshire Partnership Community Safety Partnerships Oxfordshire Stronger Communities Alliance Oxfordshire Mental Health Prevention Concordat Partnership Group Zero Carbon Oxford Partnership (ZCOP)

Selecting Indicators

Importance and Relevance

Does this indicator measure a sufficiently important question/service?

Is it a balanced set? (i.e. are all important areas covered without undue emphasis on any one area?)

Do they align with on the objectives of the strategy (3 tests?)

Validity

(Does this indicator actually measure what it is claiming to measure?)

Does this indicator really measure the issue?

Possibility

(Is it actually possible to populate the indicator with meaningful data?).

Are sufficiently reliable data available at the right time, for the right organisations with the appropriate comparators?

If not, is the extra effort and cost justifiable?

Meaning

(What is the indicator telling you and how much precision is there in that?).

Will the indicator be able to detect and display a variation that is important enough to warrant further investigation?

If the indicator is high or low, what does it actually tell you, and does it give enough accurate and precise information for you to be able to investigate further and take any necessary action?

Can the indicators be understood (and deconstructed), in order to understand the particular reasons for the results

Can the implications of the indicator results be communicated to, and believed/appreciated by the right audience

Implications

(What are you going to do about them?).

Is there sufficient understanding of the system so that any issues identified can be investigated further and addressed effectively?

Are the results likely to induce perverse incentives and unintentional consequences?

Can the indicator monitor the issue regularly enough so that further investigation and action can be taken before the issue is revisited?

Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Partnership (ICP)

Date of meeting: 21 March 2023	**Paper no:** 07.2

Title of paper: Our approach to planning, recovery and transformation

Paper is for:	**Discussion**	✓	**Decision**		**Information**	

In 2024/25, we are seeking to define a set of system goals and priorities that will deliver improvements for our residents, people and wider system. These priorities are developed in the context of the Joint Forward Plan (JFP) and Integrated Care Strategy, published in 2023, which continue to provide the strategic framework for our long-term ambition.

The purpose of this paper is to build on the ICP conversations held in November 2023 and January 2024 and provide:

a. An update on how we have been working with system colleagues to ensure appropriate input to the planning and priority setting.
b. An update on the development of a system approach to transformation and recovery
c. An update on the emerging details for each of our transformation focussed system goals.

Action required:

The Integrated Care Partnership is asked to:

- Note the proposed System Goals, recognising the shift towards balancing transformation with recovery and the ongoing need for collaborative system wide working to successfully deliver the changes.

Author: Hannah Iqbal, Chief Strategy and Partnerships Officer

Date of paper: 12 March 2024

Our approach to System Planning, Transformation and Recovery for 2024/2025

Overview

1. As discussed at previous Integrated Care Partnership (ICP) meetings, for the financial year 2024/25 we are seeking to define a set of system goals and priorities that will deliver improvements for our residents, people and wider system. These priorities are developed in the context of the published Joint Forward Plan (JFP) and Integrated Care Strategy which continue to provide the strategic framework for our long-term ambition.
2. In December 2023, updated guidance on the publication of Joint Forward Plans was published which re-iterated the purpose of the JFP is to describe how the "*ICB and its partner trusts intend to arrange and/or provide NHS services to meet the physical and mental health needs of their population. This should include the delivery of universal NHS commitments, address ICSs' four core purposes and meet legal requirements.*"
3. Systems continue to have the same flexibilities to determine the JFP scope and structure and it is expected that for the majority of systems, plans will reflect a continuation of those published in 2023.
4. Recognising the BOB system continues to face significant financial and operational pressures, our refresh activity has focussed on defining a small number of priorities where we believe the greatest benefits will be seen from cross-system working – Our System Goals
5. This paper builds on the ICP conversations held in November 2023 and January 2024 and provides:
    a. An update on how we have been working with system colleagues to ensure appropriate input to the planning and priority setting.
    b. An update on the development of a system approach to transformation and recovery
    c. An update on the detail and next steps for each of our transformation focussed system goals.

Engaging on the System Goals

6. We have previously set out our 2024/25 process for developing the systems goals, ensuring wide engagement with partners. Since January, we have built on our engagement by undertaking further discussions to agree priorities within:
    - **System Board Discussions** – Themed discussions on system goals within forums such as the BOB Mental Health Partnership Board; Primary and Community Transformation Board; BOB Children and Young People's Board.
    - **BOB Joint Health Overview and Scrutiny Committee** – Discussions held with scrutiny representatives from across our three places to provide input and challenge into our system goal priorities.
    - **NHS Leaders System Workshop** – Workshop held with NHS leaders to discuss our shared financial context for 2024/25 and explore how we might need to work differently together given the challenges of system financial sustainability.
    - **NHS Leaders planning calls** – Regular CEO discussions, in addition to functional working groups of NHS system operational and financial leaders to develop approach and ensure alignment on planning assumptions.
    - **Place level discussions** – An update at place partnership meetings and other place level discussions to discuss alignment with local planning priorities.
    - **Internal ICB Planning Discussions** – Several planning workshops within the Integrated Care Board to evaluate investment requirements for the next year and identify key choices to make, once statutory and mandatory requirements have been met.

Our approach to System Recovery and Transformation

7. Through the discussions outlined above, it has become increasingly clear that our system is not yet working in a way that is operationally or financially sustainable. Whilst it is too early to set out our system financial position for the next year, the system looks set to forecast a deficit position with unmitigated pressures across partners. Given the need for system operational and financial sustainability, we need to ensure we are doing all we can as a system to mitigate this through our approach to planning, priority setting and resource allocation for the next financial year.
8. In addition to our financial situation, it is also clear that we are not yet fully maximising the benefits of system working to improve outcomes and transform the way we deliver healthcare. Shifting our focus to prevention, using data to segment our population and target resource, drawing together multi-professional teams around pathways will allow us to improve outcomes, manage demand and release efficiencies. However, the operational challenges of today are constraining our ability to transform our system in ways which will have lasting benefits.
9. To achieve the level of transformation that we require, we will need to develop greater clarity about our shared direction, followed by closer alignment and coordination of our system resource to achieve our priorities. We will also need to be clearer on how, within a challenging operational environment, we maintain the leadership headroom, capability and capacity required to drive change across the system, keeping track of our progress as we go.
10. Taking these together, we will adopt a dual focus on system recovery and transformation over 2024/25 and likely beyond. To support this, it is proposed that from April 2024, we set up a new System Recovery and Transformation Board to oversee the delivery of the BOB System Goals, focusing on driving both system recovery and transformation. The original goals will be strengthened to provide a more robust approach to driving financial efficiency and operational improvement. In addition, the first goal will be broadened to include a wider focus on transforming primary care through Integrated Neighbourhood Teams and the addition of Same Day Access, reflecting the Primary Care Strategy. The implementation of this will be held until the final strategy is approved (expected Spring 2024).
11. Driving transformational changes in a complex and operationally challenged system will require a level of skilled and dedicated resource. We are therefore looking to set up a System Delivery Unit, which will be hosted by the ICB and will support the System Recovery and Transformation Board by ensuring effective implementation of the System Goals and constituent programmes of work.
12. We are also exploring further resourcing opportunities such as how we might work differently with partners including NHS, Local Authorities and the VCSE sector underpinned by a social investment approach. These discussions are ongoing but would bring potential investment into BOB which could be used to pump prime preventative initiatives and support community based initiatives, most likely led by VCSE organisations.

Updated System Goals 2024/2

13. Considering the context described above, our System Goals, have now been deliberately separated into those focused on *Prevention and System Transformation* and those focused on *System Recovery and Improvement*. This is shown in the diagram on the next page.
14. This separation aims to ensure that across our system, we can hold the tension of addressing the immediate need to deliver improved performance and financial sustainability, with the need to make longer term changes that support our populations be healthy and well in their communities for longer. Over time, these goals will also all play a role in reducing demand and ensuring a better use of system resources.

15. Since January, each of the transformation focussed System Goals has been developed to include additional detail on the rationale for its inclusion, the proposed scope of the programme and the expected outcomes that will be achieved, including how success will be measured. Additional details of the *Prevention and System Transformation* goals can be found in Appendix 1. These continue to be iterated and developed further.

16. The *System Recovery and Improvement* goals will continue to be refined in March through discussions with partners in preparation for the first Recovery and Transformation Board on 12 April 2024. Given the ongoing discussions relating to the System Recovery approach and the system financial position heading into next year, this paper only includes indicative detail of these. This is also due to ongoing work to reset our approach to system efficiency from next financial year, including how we utilise and build on the work of the ICS Efficiency Collaboration Group.

Asks of the Board

The Integrated Care Partnership is asked to:

- Note the proposed System Goals, recognising the shift towards balancing transformation with recovery and the ongoing need for collaborative system wide working to successfully deliver the changes.

Next steps

17. The ICB team will continue to work closely with leads to refine the System Goals and the process for monitoring delivery progress. This will be in alignment with any final requirements identified from the NHS operational planning process and agreed changes resulting from engagement on the Primary Care Strategy.

18. Reporting on delivery progress will be made at subsequent public meetings of the ICB Board with regular updates to the Integrated Care Partnership.

Appendix 1: additional detail on each of the proposed 2024/25 System Goals

BOB SYSTEM GOALS			
Goal		**Rationale**	**KPIs**
Transform Primary and Community Care by delivering improved Same Day Access and bringing together teams and resources across organisations into Integrated Neighbourhood Teams	**Integrated Neighbour-hood teams (INTs)**	**Rationale** • Over 50% people have at least one longstanding health condition. Over a quarter of the adult population live with more than two. • Long-term conditions associated with older age such as dementia will increase in prevalence with our aging population. • Early detection and coordinated management of these conditions is critical. Population Health Management (PHM) allows for development of targeted early interventions to proactively improve outcomes and address health inequalities. • Improving proactive out-of-hospital care for priority groups keeps more people in their communities longer, reducing acute care demand.	
		Scope of Work • Rollout new INTs in the place geographies with a multi-disciplinary and cross-organisational model, targeting early interventions and proactive care for patients with complex support / care needs. • Confirm common BOB-wide INT principles and model. • Stocktake of current best practice and learning. • Create a reliable model for risk-based population segmentation using PHM methods.	
		Outcomes / KPIs • At least 3 INTs operating in each BOB Place by end of March 2025 • % of identified (high risk cohort) patients cared for by an INT by Q4 • Reduction in avoidable admissions (% reduction from defined cohort)	
	Same Day Access	**Rationale** • Population growth and shifting demographics are driving up demand for primary care. Without a care model change, a 55% increase in GP appointments will be required within a decade. • Since 2021, accessing primary care has become more difficult. Positive responses relating to appointment booking have decreased by 19%. • Around 70% of population health needs are low complexity, accounting for roughly half of GP activity. These needs can often be directed to other primary care services like community pharmacies or virtual/physical access hubs. • In the BOB ICS GP National Survey, it was reported that 10% people went to A&E when they couldn't get a GP appointment and 30% attended when the practice was closed.	
		Scope of Work • Support rollout of Same Day Access model and develop new plans for ongoing implementation. • Clarify and share the PHM offer to segment our relevant populations. • Agree common features, principles and enabling support based on good practice and shared learning.	
		Outcomes / KPIs • Improved patient experience. • Released capacity in General Practice. • Enhanced staff satisfaction in PCNs where model has been implemented. • Increased referrals to alternative pathways	

Support our children and young people (CYP) who are accessing Neurodiversity or mental health support services	**Develop a system-wide needs led approach to supporting children and young people with a diagnosis of or suspected autism/ ADHD**	**Rationale** • In December 2023, BOB had over 11,000 CYP on the neurodiversity waiting list with an average assessment wait time of 92-102 weeks, exceeding the national average. • 80% of CYP inpatients have autism or suspected autism. • 70% of Neurodivergent children and young people have comorbid mental health difficulties
		Scope of Work • Improved support offers for children and young people in our clinical pathways waiting for an (ASD /ADHD) assessment. • Implement the THRiVE framework including piloting and evaluating schemes to introduce more early needs-based support in BOB working with system partners including VCSE and education providers. • Deep dive into avoidable inpatient admissions that informs proactive planning to prevent avoidable admission
		Outcomes / KPIs • Increased number of people accessing preventative early intervention support • % reduction in avoidable hospital admissions • Targeted mobilisation of Hospital at Home Model for children and young people with moderate to severe Learning Disability/Autism
	Improve the emotional mental wellbeing of children and young people	**Rationale** • Demand for CYPMH services has grown by 32% since 2017, with greater acuity and complexity of need. • Around one in five CYP aged 8 to 25 years had a probable mental disorder in 2023. • Over 17,000 CYP have received support or treatment for a Mental health issue in the last 12 months. • Waiting times for CAMHS services vary significantly across BOB
		Scope of Work • Scale up preventative early needs-based support and intervention in schools, focussing on inequalities, working collaboratively with system partners. • Identify and support regular users of our urgent/emergency MH and Acute services who often have complex support needs. • Strengthen our Mental Health Support Team (MHST) coverage across BOB
		Outcomes / KPIs • Increased number of people accessing preventative or early intervention support including MHSTs / counselling in schools • % reduction in avoidable hospital admissions by 2025/26 • Reducing waiting times for specialist MH Treatment (CAMHS services)

Extend healthy life expectancy by **preventing strokes and heart attacks,** through working together to improve CVD pathways and prevention and targeting action to where it will have most impact	**Rationale** • CVD accounts for 25% of UK deaths, with over 72,000 people living with relevant conditions in BOB. • CVD significantly increases premature deaths in deprived areas, with mortality rates four times higher compared to affluent communities. • Approximately 11% of BOB's population are active smokers and 3 in 5 adults are overweight or obese. • CVD prevention primarily involves lifestyle changes and community engagement, which can effectively reduce health disparities and are cost-efficient in preventing cardiovascular events.
	Scope of Work • Enhance early detection of CVD risk by widely implementing NHS Health Checks. • Address blood pressure control disparities in primary care by aligning practices with NICE guidance. Boost blood pressure checks in community pharmacies and encourage consistent self-monitoring. • Increase % of at-risk patients on lipid lowering therapies and optimisation treatments in line with NICE guidance. Prioritise lipid management within stroke and cardiology pathways (inpatient/outpatient/rehab). • Acute trusts to target and improve smoking cessation support in stroke and cardiac wards. • Focus on Patient Empowerment and Community Engagement to target approaches to smoking cessation, tackling obesity, increasing activity, healthy diets and alcohol consumption.
	Outcomes / KPIs • Over 77% of people with known hypertension are treated to age specific thresholds. • Increase lipid target achievement in CVD patients. Improve lipid management for people with QRISK >20% • NHS health checks available for staff in all trusts • More than 65% of people with SMI / LD access an annual Health Checks • Increased uptake of smoking cessation programmes from cardiac and stroke inpatients.

Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Partnership (ICP)

Date of meeting: 21 March 2024	**Paper no:** 08

Title of paper: Ways of Working

Paper is for:	**Discussion**	✓	**Decision**	✓	**Information**	

Purpose and executive summary:

In the January workshop session, the ICP considered the report "Integrated care partnerships: Driving the future vision for health and care" produced by the Integrated Care Systems Network of the NHS Confederation in partnership with the Local Government Association. The discussion focused on what could we learn from what other systems were doing and how did we ensure the ICP added value and was doing only the things it could uniquely do. This paper summarises the main themes from the discussion and provides some prompts for further discussion to continue to develop the ICP.

A short update on future Chairing arrangements and membership is provided.

Action required:

ICP members are asked to:

- Discuss the outcomes of the workshop session and agree how they would like things taken forward.
- Approve the proposed approach to the election of a new Chair.
- Approve the proposal for DPH membership of the ICP.

Author: Catherine Mountford, ICP Secretariat

Date of paper: 12 March 2024

Ways of Working

Context

1. In the January workshop session, the ICP considered the report "Integrated care partnerships: Driving the future vision for health and care" produced by the Integrated Care Systems Network of the NHS Confederation in partnership with the Local Government Association. The discussion focused on what could we learn from what other systems were doing and how did we ensure the ICP added value and was doing only the things it could uniquely do. This paper summarises the main themes from the discussion and provides some prompts for discission for the ICP.
2. A short update on future Chairing arrangements and membership is provided at the end of the paper.

Integrated care partnerships: Driving the future vision for health and care

3. The ICP workshop session in January was supported by a Policy Advisor from the ICS Network of the NHS Confederation. The slides he used to prompt discussion are included as Appendix 1 to this paper.

4. The ICP members found it very helpful to see what others were doing and be able to reflect on what we could learn from this to support the development of the BOB ICP.

5. The following themes were raised in the discussion:

   a. The ICP is still relatively new and continues to develop (we are going through the forming-storming-norming phases). There is value in having our meetings face to face as this builds the team and relationships, though this is difficult with our geography.

   b. There is still a lack of clarity of the roles of different organisations/elements of the system such as the ICP, the Integrated Care Board (ICB), Health and Wellbeing boards (HWB), Place Based partnerships (PBP), BOB Joint Health Overview and Scrutiny Committee. Where are decisions made? How are the conversations in the ICP different to those thet happen in the ICB Board or at place?

   c. There is a lack of clarity, understanding and buy-in to system working and "BOB" and the benefits of system working.

   d. Noted that the single statutory responsibility for the ICP is to prepare an Integrated Care Strategy. HWBs are responsible for developing Health and Wellbeing Strategies, Joint Strategic Needs Assessment, Pharmaceutical Needs Assessments and for the Better Care Fund.

   e. We have made a good start and need to build what is right for us making incremental progress.

   f. We have agreed some priorities, and it is important to be focused; we can only do a few things. We need to be evidence based, make commitments, and deliver them. There was a recognition we have capacity challenges so cannot take on too broad a remit. The work on developing System Goals and understanding how these are going to be delivered contribute to driving focus.

   g. We need to ensure that we are focused on outcomes and deliverables to ensure the ICP and our meetings are adding value and not duplicating what happens in place. The ICP has always stressed the importance of subsidiarity and delivery in place. Do we need to ask HWBs and PBPs what they want from the ICP?

h. Our agendas/focus to date has been quite health focused and we need to ensure a focus on prevention this needs to be widened out. We shod be thinking about the interactions between health, social care and wider services.

i. The different rules applied to funding and budgets for different parts of the system, for example, NHS and local authorities, can cause difficulties.

j. How do we ensure we are service user focused and hear the voice of our residents? Do we need to think about having a broader forum; the idea of a wider Assembly has been raised before.

k. Moving forward members agreed we needed to think about
   i. Clarity of purpose of ICP
   ii. Benefits of system working
   iii. Building trust and confidence in each other and across organisations
   iv. Ensuring we are focused on our residents and ensuring we have mechanisms to hear their voices.

6. The following prompts are provided to stimulate discussion by the ICP and to agree a way forward:

a. Clarity of purpose and understanding the roles of different parts of the system. What would members find help to address this?

b. Benefits of system working. Is the proposed focus on System goals enough (which would then drive the forward plan) or do we need to do more?

c. Continuing to build trust and confidence in each other; we have agreed that part of this is meeting face to face, and it is linked to delivering on some joint commitments. Is this enough or do we ned to do more?

d. The ICP has thought about broader input, development of an Assembly before. This would take time and capacity to do support so the ICP needs to agree what it would want to achieve from this.

e. Currently the ICP has agreed it meets five times a year with each session split between a meeting in public and a workshop session. Does it want to continue with this pattern?

Future Chairing arrangements and membership

Future Chairing Arrangements

7. The ICP Chair, Councillor Brock has announced his decision to stand down both as Leader and as a Councillor. He will not be standing in the elections that are taking place in May so this will be his last meeting as Chair of the ICP.

8. The Chair is elected by the Founding Bodies (the local authority councillor and ICB members). It is proposed that the ICP secretariat writes to these members to seek nominations and then facilitate the election. The ICP are asked to **approve** this approach.

Membership

9. At the meeting in January the ICP discussed Director of Public Health membership of the committees as there are now four DPHs (as opposed to the three there were at time of establishment of the ICP). In discussion the ICP expressed an openness to continue with four DPHs, but there was a discussion about the balance of representation and no conclusion was reached.

10. It is proposed that all four DPHS should be members of the ICP but that there is only one vote between the two DPHs for Berkshire West. The ICP are asked to **approve** this approach.

11. **The ICP members are asked to:**
    a. Discuss the outcomes of the workshop session and agree how they would like things taken forward.
    b. **Approve** the proposed approach to the election of a new Chair
    c. **Approve** the proposal for DPH membership of the ICP.

NHS Confederation

Integrated Care Partnerships: driving the future vision for health and care

Ian Perrin, Senior Policy Advisor – ICS Network

Integrated Care Systems Network
NHS Confederation

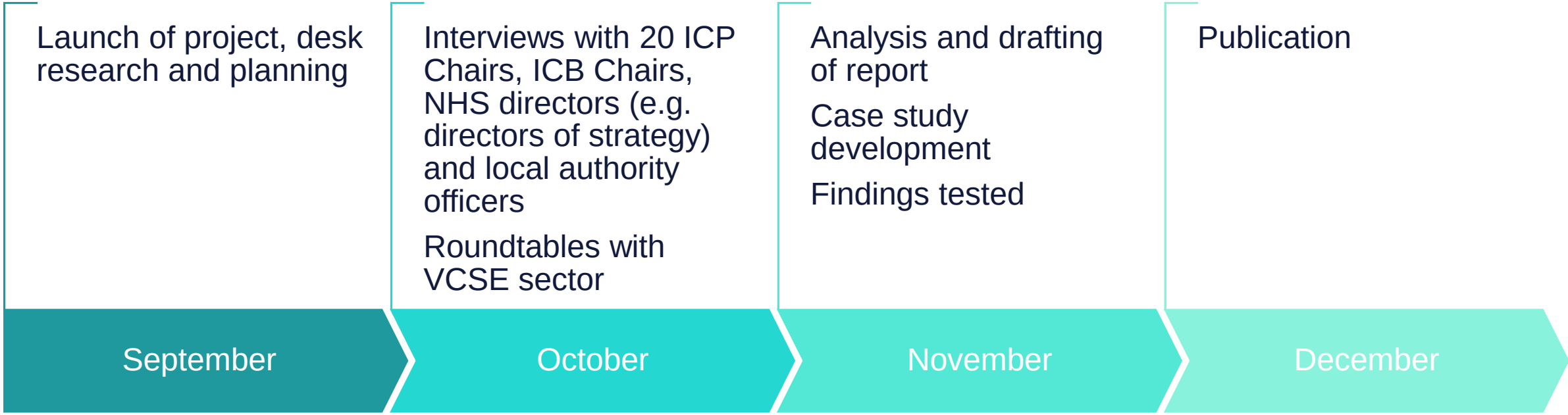
Local Government Association

Aims of research

To encourage colleagues in systems to explore the potential of ICPs beyond their statutory duty

To showcase examples of best practice across the country and promote shared learning

Process


Launch of project, desk research and planning
Interviews with 20 ICP Chairs, ICB Chairs, NHS directors (e.g. directors of strategy) and local authority officers
Roundtables with VCSE sector
Analysis and drafting of report
Case study development
Findings tested
Publication
September
October
November
December

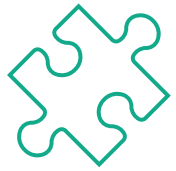
NHS Confederation

Findings

Integrated Care Systems Network
NHS Confederation

Local Government Association

Three core purposes of ICPs



Convenor

Change

Challenge

“Convenor” Partnerships

In a “Convenor” partnership, the primary purpose of the ICP is seen to be bringing a broad group of partners together to set and pursue shared objectives and take collective action.

In these partnerships:

- There is often an **‘engine room’** or ‘core committee’ which drives action, and an **‘assembly’** aimed at establishing a broad coalition of partners.
- There is a focus on **consensus-finding**, identification and pursuit of **shared priorities** and agreeing how to use all the tools at partners’ disposal to have maximum impact for their communities.
- The work is **strategic**, driving delivery among its partners.
- It can act as a **‘mediator’ to help find solutions**. It acts, in the words of one interviewee, as a “non-political wrap of film around the system”.

Spotlight: “Convenor” Partnerships

How Humber and North Yorkshire ICP is setup to make the most of its partnership

- ICP meetings are structured for maximum partner contribution
- Designed to balance ‘here and now’ priorities with ‘strategic’ priorities across the system.
- The ‘ICP Meetings Day’ takes place quarterly, for a whole day and is held in person.

1. Chief Execs Meeting
2. The Place Leadership Board
3. The Futures Group
4. Plenary session

“Change” Partnerships

In a “Change” Partnership, the primary purpose of the ICP is to identify cross-system priorities, to immerse itself in their detail, and to drive transformative change to provide maximum impact for the population it serves.

In these partnerships:

- The focus is on bringing together **the right cast of actors** to make change happen.
- **This cast of actors may vary depending on the issues** being prioritised, though there will be a consistent core group, including the ICB and local authorities no matter what issue is being prioritised.
- The partnership’s role is to draw on the **broadest range of expertise to have maximum impact**, often thinking in non-traditional terms – e.g. a shift away from typical NHS levers for change.

Spotlight: “Change” Partnerships

How Devon ICP is realigning system focus to drive transformative change

- Recognition across ICS that SEND services require cross-system action to improve.
- ICP has agreed to prioritise children and young people’s mental health, with particular focus on SEND

“The ICP is going to be the catalyst to make this change happen. My gut feeling is that partners across the system are really pleased we’ve taken this step and it’s now time to start delivering the change.”

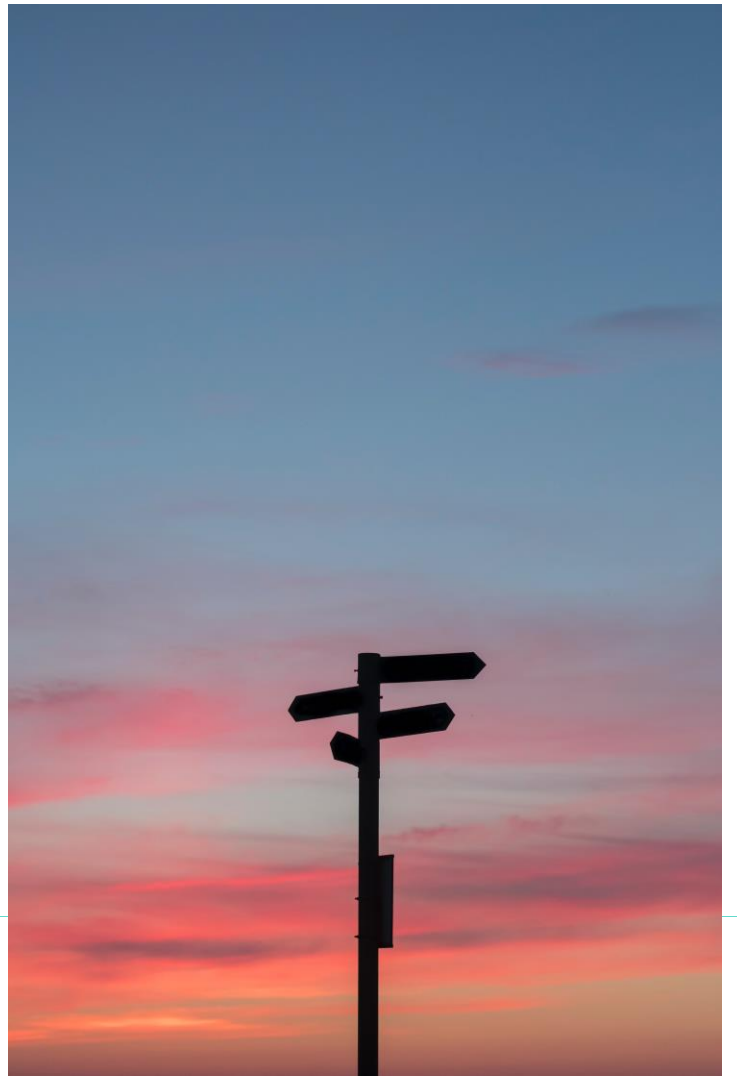
Cllr James McInnes, ICP Chair, Devon

“Challenge” Partnerships

In “Challenge” Partnerships, their purpose is to provide a counterweight – or challenge – to what is often the NHS’s focus on short term priorities, such as forthcoming winters, elective backlogs, acute performance, and GP waiting times.

In these partnerships:

- Their leaders are explicit about a **focus on the wider determinants of health** (e.g. housing, climate change, education, socioeconomic development).
- Leaders focus on the **strategic direction of the system in its broadest sense,** and its long-term ambitions, rather than practical delivery in the here and now.
- They **can be seen to have an accountability role, using integrated care strategies as the lever** to drive change.



Spotlight: “Challenge” Partnerships

How Black Country ICP is driving a focus on the wider determinants of health

- 50 percent of population living in lowest indices of deprivation
- Strong correlation between deprivation and social housing
- Decided focus of inequality surrounding Type II diabetes
- Partnered with the Housing Partnership Manager (ICB funded) to create a monthly forum and Community Champion Service.
- Outcomes after six months: provided gainful employment to ex-service users and improved outcomes for diabetes

Seven common characteristics of effective ICPs

Spotlight: Enabling wider participation

Suffolk and North East Essex ICP

- Suffolk and North East Essex ICP hosts an annual expo, bringing together partners from across the area to celebrate their work, build relationships and set plans for the future.
- The theme for this year's event was 'The Future is Now: Time to Value Every Voice in Health and Care' – a conscious effort to draw in all partners from across the system.

Figure 1: Suffolk and North East Essex Annual Expo 2023

The future of ICPs

We asked ICP Chairs what they hoped their ICPs would achieve over the next 3-5 years…

“Tangible shift towards prevention”	**“Make huge gains in data sharing, particularly for CYP, and outcomes such as educational attainment.”**	**“Better understanding of best practice in population health”**	**“Want to see shrinking acute services and a growth in community support across NHS, LA and VCSE.”**
“A shared sense of identity and ownership over vision”	**“Making an impact for children with special educational needs and disabilities (SEND)”**	**“Progress on social connectedness, trauma-informed care, and mental wellbeing”**	**“Progress on co-production with examples of where this has led to service change and improved outcomes for more deprived communities”**
“Greater transparency on how the ICP is achieving its vision”	**“Stronger relationships with VCSE partners and district councils”**	**“An ICP that supports and enables change at ‘place’”**	**“Reducing poverty – and the variation of deprivation across the geography”**

What do we **want to achieve in three to five years**? How are we going to achieve that?

Do we have a **shared vision and set of priorities**?

How can our ICP **enable better social and economic development**?

How is our ICP **setup to help tackle the wider determinants** of health?

How do we **add value** to what is being done elsewhere? What's the ICP's **unique contribution** to make?

Is our ICP **setup to make participation easy**? And are we **articulating its unique value** to attendees?

Thank you

Ian Perrin, Senior Policy Advisor – ICS Network

Ian.perrin@nhsconfed.org

Integrated Care Systems Network
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