PROJECT ROME

MIKE FARRAR CONSULTING LTD

BRADFORD DISTRICT AND CRAVEN INTEGRATED HEALTH AND CARE SYSTEM

AN INDEPENDENT REPORT ON THE NEXT STEPS OF THE JOURNEY TOWARDS INTEGRATED CARE - 2022-25

DRAFT REPORT V1.1

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BACKGROUND

Context

Subject to the Integrated Health and Care Legislation making its journey through Parliament, the West Yorkshire Integrated Healthcare System will come into being on 1st July 2022'. At its heart will be the 5 integrated places that will serve as its engine room, driving population health improvement, reducing inequalities and delivering on key national health priorities including elective recovery and financial sustainability.

Health and care organisations and services in Bradford District and Craven have made great progress over the last 5 years since the area first begun to conceive of the intention to develop health and care systems with a strong focus on place based working and population health. But all parties recognise that there is now a need to consider the next stages of their journey in light of

- the COVID-19 experience (with its lessons on:- swifter decision making; new ways of working such as digital/virtual services; staff flexibility; the role and future of NHS 'commissioning'; and the epidemiological and psychological impact of the virus on different population groups)

- the immediate advent of policy and legislative change for the NHS and care system being considered nationally,

- the review of the Local Government arrangements impacting on the Craven area of the BDC patch

- challenging financial circumstances for all organisations and the people of the BDC area, especially when juxtaposed against population health and care need and demand

- need to accelerate the approach to reducing health and care inequalities in the area (specifically in the context of the recovery of service and economic standards post COVID)

- frustration that BDC has described its move to integrated care for many years but this has been felt, on occasions, to be only partially achieved and so acceleration may now be needed.

As a consequence Bradford District and Craven has chosen to assess its current position and consider what might be its next steps for its local health and care system relationships if it is to deliver its mission. It's leaders view the means by which they organise and deliver health and care over the next 3-5 years as crucial if they are to be successful.

Methodology

Mike Farrar Consulting Ltd was commissioned to undertake an independent identification and assessment of options for developing organisational relationships and shared leadership across Bradford District and Craven in the context of the journey to greater integrated care delivery.

The fieldwork, undertaken in January and February 2022 has included -

- interviews with individual leaders

- facilitated discussion sessions with Boards on their perspectives of organisational futures and leadership options

- independent input considering evidence from elsewhere and other sectors

- testing of emerging insights with the Partnership Leadership Executive (PLE)

This, with a view to presenting the final draft report to PLE, and to the ICP NED/Directors Group in March and the final report new Strategic Partnership Board in April.

SECTION 1 - FRAMING THE CHANGE

Key Findings

1.1 BDC has a great starting point and a very positive history of history of joint working

The Bradford District and Craven patch has a long history of joint working between its constituent statutory, non statutory and independent health and care organisations.

There is a shared mission and purpose in its commitment that its residents should be '**Happy and Healthy at Home**' which has been fully embraced within its 'ActAsOne' partnership programme.

It's organisations have found the emerging new national system to be well aligned with their local approach and have used the auspices of the reform of its commissioning group to establish a new forward looking Strategic Partnership Board (as a sub committee of the West Yorkshire ICS) which is supported by a Partnership Leadership Executive.

The Board will overarch numerous operational joint working structures and approaches (care pathways, sectoral collaborations etc) and will bind together the sovereign constituent organisations such as the NHS Trusts and Local Authorities, Primary Care and the VCSE sector to oversee the spending of health, and in some cases, care monies.

This new Board is directly informed by an overarching Health and Well Being Board structure that enables joint ownership of the public health challenges across each local Authority area.

1.2 BDC leaders have the idea, the will but maybe not had the same success in execution of their ideas in the past

Whilst much has been achieved up to this point through previous joint working structures, there is a universally felt sense that the health and care system has greater potential to move its integrated health and care agenda forward. This is coupled with a sense of frustration that despite best efforts, the local system is still fragmented and sometimes witness to 'individual', often described as 'parochial' behaviours, that belie the stated intent of all leaders and organisations to 'act as one'.

Examples cited include the views of some leaders on the - failure to make shared organisational senior appointments, the multiple competing capital bids, and the lack of evidence that a long held intention to move resource to primary care and earlier intervention has been realised,

There is also a concern that when the CCG (and its leadership) goes, there may not be enough maturity in the provider relationships to sustain a shared approach to achieving the mission.

In summary, there is agreement to the *idea* of greater integration, there is a *will* expressed by all parties to achieve it, but there is a lack of agreement across them on how they would *execute* this, and a concern that some, but by no means all, past experience would suggest a triumph sometimes of the joint working rhetoric over the reality.

1.3 Structural Change is not an easy or necessary starting point

The concern relating to the failure to execute previous 'integrating' actions is compounded by some leaders in the system having a deeply felt ***fear***, or alternatively for others, a deeply felt ***conviction***, that integration will only be achieved through structural change.

In my view this has led to a slowing of the pace of integrating care, due to some local system leaders being more *defensive* rather than more *open* to establishing deeper relationships especially if these might be conceived to be the beginning of structural change

As a consequence, there is no widespread agreement within the leadership group to go further faster on any structural change, and as such I believe that attempting to move to a single integrated provider organisation, for example, across Bradford District and Craven at this stage would create opposition, distraction and would take many years for the delivery of any potential benefits of a single governing structure.

1.4 However, the successful delivery of BDCs mission is amenable to wide ranging actions that require little or no structural change. but do require a refocusing of leadership priorities

Of equal importance is the recognition that BDCs mission of being happy and healthy at home is amenable to actions that do not in themselves require significant structural solutions

Historically a lot of leadership effort has focused on the relationship between Bradford and Airedale acute hospital services as the totem for integrated healthcare yet in terms of delivering 'happiness and integrated care at home', this would require a greater focus on prevention, community action, population health, primary care, community, mental health and children/young peoples services

1.5 There are three areas for action that would strengthen BDCs approach to integrated health and care

Despite the desire to stay away from structural change and with the opportunity to refocus leadership and priorities towards wider health strategies, there is still a significant opportunity to take steps towards greater integration and collaboration in the system.

I believe there are many practical steps that can and should be taken and I would group these into three main areas of activity -

- supercharging the neighbourhood and community level work - potentially establishing 'Community and Primary Partnerships' (CPPs)

- formally strengthening the operational provider relationships to capitalise on existing programmes and ensure joined up service delivery for patients, service users and the BDC population

- establishing effective priority setting, resource allocation and strategic decision making through the new Strategic Partnership Board

SECTION 2 - PROPOSALS FOR CHANGE

2.1 Supercharging the neighbourhood and community level work - establishing Community and Primary Partnerships (CPPs)

2.1.1 Current arrangements are too varied, under resourced and underpowered

The BDC system currently has a series of community partnerships which operate variably in tandem with Primary Care Networks across its geography. These vary as to their role, approach, work programme, capability and effectiveness and yet they need to fulfil a vitally important role in the delivery of the healthy and happy at home mission

I believe that if BDC is to be successful, it needs to 'supercharge its neighbourhood and community activity through a revamped and constituted new approach, which I have termed the development of Community and Primary Partnerships (CPP) but could be differently named locally

2.1.2 Eight Key Functions of CPPs

CPPs should be responsible for delivering a number of crucial functions which, as a minimum, would include the following 8 key areas (recognising that some programmes of work in these areas are already in place but might benefit from greater systematisation) -

developing a systematic programme of community engagement (similar to the well evaluated programmes run in Wigan and in St Helens)

establishing a strong platform for population health management, including through the coordination of data to enable the system to target resources much more closely to need,

undertaking a primary prevention programme that incorporates bending non health and care spend to deliver the basics of a healthy life (eg a home, a purposeful role or job, and family/social support services) and the provision of primary preventative services such as smoking cessation, screening, vac and imm etc, drawing on community pharmacy as well as general medical, dental and ophthalmology practice

assuring a consistent approach to secondary prevention, with PCNs addressing unwarranted clinical variation amongst primary practitioners in a supportive and learning culture

working as the operational basis for integrated community services that work holistically (addressing mental, physical and social needs) for complex patients and those at greatest risk of hospitalisation and permanent loss of independent living

working with partners in secondary health and residential care services to coordinate and deliver the diagnostic and outpatient processes along with virtual wards and a systematic approach to access generalist and specialist opinion

promoting the use of new technologies to enable citizens to understand and maintain their own health; virtually monitor chronic disease and flag any deterioration for those waiting for care

develop new innovative service offerings that enable health and care to be delivered in out of hospital settings

2.1.3 Priorities and Financial Commitment

In BDCs current situation, their focus should be on delivering the current commitment to a 1% shift towards prevention and earlier intervention , through new service developments, whilst deliberately and specifically planning to make further percentage shifts each year for the next 3-5 years

The initial focus should also be in addressing BDCs hotspots such as the long waiting areas, and crucially supporting the improvement in the Children and Young Peoples services along side Local Authorities' wider services

2.1.4 Organisation, Resources and Governance

To achieve this the CPPs will need to have a much more systematic organisational development process accompanied by resources which deliver a core consistent evidence based approach but also have sufficient local variability to enable them to be sensitive to varying local need and to tackle inequalities

The resource needed for CPPs will include both capacity and capability with investment in CPP leadership (using a clear competency based leadership model), and the introduction of good governance principles

CPPs would have oversight of the resources used within the locality with delegation for resource use (but this would be in relation to the soft budgets rather than devolution of hard budgets)

CPPs would be partnerships of all organisations in particular centred on VCSE, PCNs and community services with agreed approaches to governance (membership and leadership) sitting within a broad consistent framework whilst reflecting local relationships. They should be supported by strong and effective community engagement and have a culture of citizen, clinical and care professional empowerment (NB The work being undertaken by David Hambleton will helpfully inform these developments in timely fashion).

There will be a key role for the Community Provider Trusts, PCN and VSCE leaders and the LAs to develop and support the establishment of CPPs, and this would include providing the infrastructure, O/D, leadership development and governance facilities

NHS Trust Boards need to recognise the value of the delivery of services at community/neighbourhood level and agree within their own organisational operating principles to delegate decisions within this system and to empower their own teams working at this level

2.2 Formally strengthening the operational provider relationships to capitalise on existing programmes and ensure joined up service delivery for patients, service users and the BDC population

2.2.1 There is a need to build on previous changes to integrate purchasers and providers, but also to review and move forward from the status quo

The BDC system has previously adopted a series of models for provider collaboration including the establishment of provider alliances in both Bradford and in Airedale. These models have largely been overtaken now, in any formal decision making sense, by creating the PLE, the establishment of the ActAsOne programme and now the SPB

The deliberate intention of these moves has been to -

collapse the purchaser provider split in order to foster collective priority setting, decision making and allocation of resources

enable decisions to be taken on the full BDC footprint as appropriate

engage providers from across the whole spectrum of VCSE, primary care, Local authorities and NHS Trusts as equal partners into a shared management and oversight process

encourage these providers to take responsibility for achieving key outcomes for the population within the fixed envelope of resources, thereby encouraging them to innovate and find both allocative and technical efficiency

These moves are strongly supported by constituent organisations and I would argue mirror global evidence on successful integration of health and care. The principles of these changes auger well for BDC in terms of strategic priority setting and resource allocation (see 2.3), but they need to be underpinned by a process that joins up the actual delivery of health and care on the ground, and I believe there is more that needs to be done on developing shared operational capability to achieve the outcomes that BDC seeks.

2.2.2 Review of the Current Shared Operational Programmes, the scope for rationalisation and the need for Greater Alignment with BDC's Priorities, Mission and Focus

Provider collaboration within and across BDC is underpinned by a series of working groups and programme such as the ActAsOne programmes, the Health and Care Partnerships and the COVID Gold Command structures that create a series of functions and improvement activities based on specific problems, pathways or sectors

Whilst I believe the ActasOne brand is a very strongly supported approach (and should be retained and built on), and that many of these programmes have great merit (recognising that the level of maturity and effectiveness of each programme varies), I am not convinced that they are being optimised due to

the absence of a clear and consistent route into formal provider decision making that leaves the various programmes operating without a strong sense of coherence

there being a only a partial match of activities with strategic need or priorities

the lack of a forum and clear route for formal acute hospital based collaborative agreements between the two main Hospital Trusts (other than in distressed situations)

2.2.3 Clarity on the routes and models for shared operational decision making and delivery

There is also, reportedly, uncertainty as to how the outputs from these programmes arrive at management decisions (for example on financial requests or the impact on wider service changes beyond their area of activity) and then link into SPB.

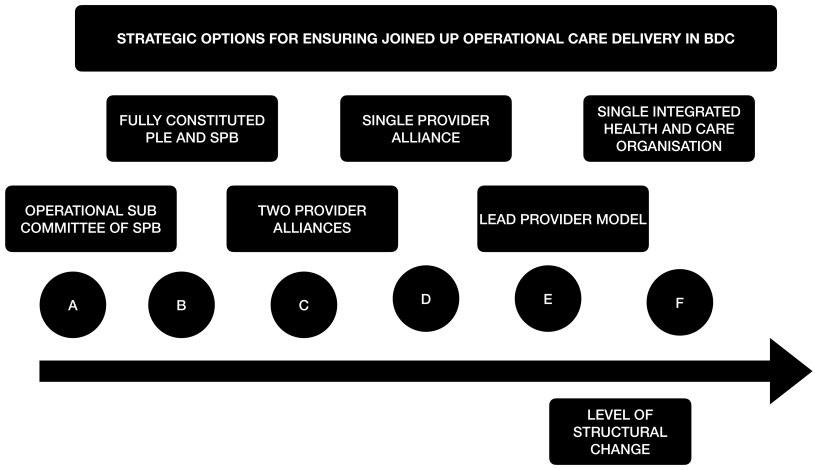
As a consequence I believe there should be a more systematic and consistent route for reporting up and down between integrated strategic decision making, priority setting and integrated operational delivery and monitoring.

In some systems such as NE Lincs, they have created a more formal Provider Alliance, the integrated care partnership (ICP) , which sits separate to their NE Health and Care Joint Committee. The joint committee, akin to SPB, consists of providers and 'commissioners', but their ICP also exists formally and ensures that any intention and priority of their joint committee can be operationally delivered in an integrated way.

In other systems, such as Bolton, S Cambridge and Hereford, they have opted for integrated operational delivery to be coordinated through a lead provider Trust, identified through the Most Capable Provider Process (in some cases this is the main place based governance structure, acting also as a local joint committee with the LA or as a sub committee of the ICB)

There is no set route or blue print for how this should happen but crucially there has to be clarity as to how strategic priorities and resource allocation converts into joined up operational delivery.

So, how should BDC ensure it has both in place? Clearly the SPB, as a formal sub committee of the West Yorkshire ICB, fulfils the role for strategic priority setting and resource allocation but there are a number of options for a structure or a process to deliver more effective joined up service delivery -



a) create an operational sub committee of SPB charged with ensuring joined up service delivery but this may run in parallel and duplicate the role of PLE

b) refocus and make more formal the role of SPB and the PLE for managing provider operational issues - such that the SPB can operate as a 'quasi committee in common' for the provider boards, in particular should they disagree. PLE would build on its current arrangements (under the Strategic Partnership Agreement) to undertake a formally constituted and mandated role to ensure that it is able to operate effectively as a shared management group overseeing and delivering joined up health and care (all HCP, ActasOne programmes and Gold Command would report into PLE directly and formally)

c) create two formal provider alliances/groups, one for Bradford and one for Craven but this would struggle to serve the cause of greater integration, especially in the context of acute to acute issues between the two NHS Hospital Trusts

d) create one formal provider alliance/group for BDC recognising that to be successful the alliance(s)/group(s) would need to include Primary Care, VSCE and LA provided services as equal partners. This route remains an option, but one which, unless it is designed and governed very precisely, might run the risk of creating

too formal a purchaser provider split

second guessing of the SPB with providers redefining priorities

duplication of decision making and extra bureaucracy

e) establish a lead provider approach using the MCPP process recognising that this would not currently be widely supported in the BDC leadership group and could also undermine the current West Yorkshire model of SPBs as sub committees of the ICB

f) move to a single integrated care organisation (collapsing the statutory organisations into one) - but, as was discussed in paras 1.3, there is little appetite for this and strong opposition in some quarters. It is also unclear how this would bind in primary care, VSCE or LA provided services

Of all the options, I believe that options b) and d) are most feasible and both would receive a measure of support from BDC organisations, stakeholders and the NHS hierarchy.

One option therefore would be to consult more widely but swiftly on these two options based on a more detailed option appraisal that includes taking legal advice on option b).

Alternatively, BDC leaders could implement the most immediately implementable option, which would be option b) as this builds on existing structures. They could then monitor progress, with a view to moving to option d) should option b) prove insufficiently capable of delivering integrated operational delivery. If this approach is adopted then I would stress *that option b) is not the status quo* as it requires

reviewing the current activity under the ActasOne programme, the work of the Health and Care Partnerships, Gold Command and the work of the Airedale Provider Alliance to ensure there is a coherent operational programme that is fully aligned to the BDC and ICS priorities and mission

establishing a clear constitution that would be signed off by SPB and individual Trusts. It would set out that PLE would take and/or recommend to Boards any shared operational decisions. PLE, would also be in position to recommend actions back to SPB on priorities, allocations and high level strategic decisions (eg major capital programmes, workforce rates, etc) that would serve to support the delivery of the agreed BDC outcomes

building functionality and a governance agreement for the SPB to operate as a quasi Committee in Common thereby enabling Trust Boards to be guided by a Non Executive led process

NHS Boards would retain their responsibility for ensuring that they deliver on their contributions to the overall performance of the system, but they will also need to enshrine within their own organisational operating principles the ability to enable shared decisions to be taken by the SPB of which their own Chair and CEO will be substantive members and by PLE where their CEO will be a substantive member.

2.2.4 The opportunity of joint operational roles and shared O/D approaches

As the initial catalyst for this review was the opportunity of a number of shared roles it would be remiss not to mention them and the obvious part they might play as the system moves forward. Despite not recommending a short term structural change, I do believe that shared roles would generally create a greater likelihood of better integrated thinking and operational delivery. .

As such I support the following -

fully supporting and empowering the new role of the Place Based Leader to ensure the post holder has the full support and access to work on behalf of all parties/organisations within the place

appointment of shared board NEDs (subject to the legislation) as a matter for immediate consideration with cross over roles established, and opportunities created as vacancies arise

appointment of shared ED (and one down) roles as opportunities arise in particular in those directorates that cover strategy, finance, HR, IM and T, and estates

a greater amount of Board to Board time allotted as part of Board development programmes

a single provider O/D programme to engage all providers including the NHS Trusts, LAs, Primary Care, CPPs, and VCSE leaders as equal partners

2.2.5 Ensuring the system has a strong clinical and care professional empowerment culture at its heart and a capability to create a single source of data, business intelligence and current supply side responses

It is essential that the BDC clinical and care professional empowerment culture is preserved and developed in order for their expertise to be built ‘in’ and ‘up’ in the new system. In particular it is vital that the voice and influence of primary care is maintained as the CCG is abolished.

For example, this could be demonstrated and delivered by the early adoption of the following 3 actions -

- ensuring that BDC appoints clinical leaders to its SPB and PLE membership (including representatives from primary care),

- that the PLE creates a new Professional Leadership Group (PLG) as part of its governance which would include PCN Clinical Directors, GP Federation leaders, and some of the GPs previously in leadership roles in BDC CCGs, along with clinical colleagues from secondary care, mental health services and professional colleagues from social care

- that BDC establishes a single data, intelligence and system planning capability that brings a flow of clinical, public health and population health data together with service supply side data to enable effective joint decision making, priority setting and care delivery.

2.3 Establishing effective priority setting, resource allocation and strategic decision making through the new Strategic Partnership Board

2.3.1 There is a hugely important role for the new SPB as it replaces the old commissioning system and creates the context for greater integration and achievement of the BDC mission

The SPB will operate formally as a sub committee of the West Yorkshire ICB, which allows it to undertake the role of resource allocation previously undertaken by CCGs, PCTs and Health Authorities before that. Unlike its predecessors, however it will be made up of organisations that have operational provider responsibilities rather than dedicated commissioning roles, and they together will oversee and deliver a fundamental reform, thereby ending the purchaser provider split. Their success in this change is mission critical for the next steps of the journey towards integrated care for the BDC system.

The main functions of the SPB will be to set priorities (based on a combination of national and local priorities), allocate resources to achieve these tasks, agree or delegate strategies and plans for operational delivery of these tasks, support operational delivery by taking strategic decisions that require a full BDC place based perspective and holding itself and its constituent parties to account for delivering their contributions and the overall mission

2.3.2 There are 9 success criteria against which the SPB should assess its initial capability and competence and then ultimately its ongoing performance

- SPB must recognise that with the resources available and the priorities/outcomes it aspires to, it will need to be a 'system transformer' rather than simply a 'system manager'

- SPB must set priorities and outcomes based on a combination of national and local perspectives and therefore must be fully informed by the views of the two Local Authority Health and Well Being Boards

- SPB must allocate money into the system in such a means to recognise the contributions of all organisations involved in the pathway (beginning with communities themselves, primary care and through to NHS Trusts). This will need provider members of SPB to ensure that they can steer SPB to do so in a manner that aligns the incentives for each organisation appropriately to the mission, facilitates joint stewardship of resources and allows them to operate with risk and gain share

- SPB must work closely with its constituent LAs to align and/or pool as appropriate, their resources for social care, public health and back office services with NHS budgets such that it can oversee and operate 'holistically' (in line with the Alma ATA definition of health as 'the absence of physical, mental and social well being')

- SPB must pursue a strategy that blends the opportunity for providers to improve productivity through technical efficiencies with the opportunity of creating allocative efficiencies through the

deliberate but gradual shift of resources towards prevention along with earlier interventions in the health and care pathways. It should not see these as polar alternatives.

- SPB must actively engage its constituent Local Authorities in how they might use their non health and care spend to deliver a health and care dividend (thereby truly connecting in to wider place based work on economic recovery, educational and environmental development etc)

- SPB must use its role to influence decisions and allocations at a wider West Yorkshire level both through its position within the ICS structures and through its Trusts, working as major players within WYAAT. This will be made easier by BDC delivering on its agreed contributions to the wider West Yorkshire outcomes

- SPB must agree from the outset the areas for shared decision making that it believes should be taken on the full BDC footprint. These will need to be agreed but would be likely to cover for example - major capital allocations and priorities, workforce pay rates, use of quality improvement and recovery resource, IM&T interoperability issues etc

- SPB must have direct oversight of a shared business intelligence function that allows it to have the full picture of the systems need, capabilities and performance

Once again, it is worth stressing that NHS Boards will retain their responsibility for ensuring that they deliver on their contributions to the overall performance of the system, but they will also need to enshrine within their own organisational operating principles the ability to enable shared decisions to be taken by the SPB of which their own Chair and CEO will be substantive members and by PLE where their CEO will be a substantive member.

SECTION 3 - IMPLEMENTING THE CHANGE - TEN RECOMMENDATIONS

3.1 Ten Key Recommendations for the Implementation of Change

Based on the detail in all the sections above I make 10 specific recommendations for action in order to make progress over the next 3-5 years -

Framing the Change

Recommendation 1 - BDC leaders should focus their action in 3 distinct areas, with the aim

i) to supercharge the neighbourhood and community level work - by potentially establishing 'Community and Primary Partnerships' (CPPs)

ii) to formally strengthen the operational provider relationships to capitalise on, make coherent and align their existing programmes and ensure joined up service delivery for patients, service users and the BDC population

iii) to establish effective priority setting, resource allocation and strategic decision making through the new Strategic Partnership Board

Proposals for Change 1 - Joined up Neighbourhood/PCN working - CPPs (or equivalent form)

Recommendation 2 - BDC leaders, in supercharging their activity at neighbourhood level, should develop CPPs (or similar arrangements) that build on and standardise their existing arrangements but are empowered to deliver the 8 key functions listed in section 2.1.2

Recommendation 3 - BDC leaders (and their organisations) should delegate responsibility and commensurate authority to CPPs (or equivalent form) to deliver the 8 key functions and then they should commit resource, leadership development and organisational development to ensure that they can be successful, whilst offering governance support through the statutory community provider organisations (This would be informed also be David Hambleton's work)

Recommendation 4 - BDC leaders should fulfil their commitment to the 1% shift in resources towards prevention and earlier intervention; and consider doing so on a progressive annual basis for the next 3-5 years

Proposals for Change 2 - Joined Up Operational Delivery

Recommendation 5 - BDC leaders should strengthen their ability to enable shared operational delivery of health and care through either

i) conducting an option appraisal of establishing a formal provider alliance or formally reconstituting the PLE as a management group for shared decision making with clear processes for reforming and improving integrated operational working, or

ii) moving straight into reconstituting the PLE as a management group for shared decision making, with a view to monitoring this approach and moving to a provider alliance should, this be proving to be ineffective and not joining up operational delivery

Recommendation 6 - BDC leaders should review and refresh the current range of operational programmes to align them with their mission and priorities (which must include elective recovery, the 1% resource shift and the improvement of Children and Young Peoples services as a minimum), ensure they have clear measurable outcomes, are properly resourced and led and that they fall clearly within the oversight of PLE

Recommendation 7 - BDC leaders should specially create a work programme that covers the shared working between Bradford and Airedale NHS Trusts to enable greater joint working and service delivery (including the consistent application of standardised pathways, the optimisation of capacity, the development of a shared workforce plan, and the protection of fragile services)

Proposals for Change 3 - Joined up strategic decisions, resource allocation and priority setting

Recommendation 8 - BDC leaders should invest time and resource to ensure that the SPB is effective, and test the current functioning, capacity and competence against the 9 success criteria listed in paras 2.3.2

Implementing the Change

Recommendation 9 - BDC Leaders should take the opportunity to

i) fully support and empower the new role of the Place Based Leader to ensure the post holder has the full support and access so that they can work on behalf of all parties/organisations within the place

ii) create a joint NED and ED/Board organisational development programme including with LA, VCSE and the PCN leaders. This would encompass work on organisational conduct and behaviours

iii) assess the value and opportunity of appointing shared NEDs

iv) assess emerging vacancies at senior level in their organisations with a view to increasing the range of joint posts and shared functions in key leadership roles

v) take steps to ensure that the new system has a strong culture of clinical and care professional empowerment

vi) ensure they are supported by a shared data and intelligence function that enables all parties to see the whole picture of need and performance

Recommendation 10 - BDC leaders should commit to these recommendations and mandate their Place Based Leader and Chair of SPB to lead their implementation. They should also review progress annually with a view to considering if the implementation of this plan is actually enabling the delivery of their mission and outcomes. In light of this assessment they should consider whether further steps towards more formal structural change would be beneficial.