Integrated Care System NI

# ICS NI Test AIPB Evaluation Report

HSC Health and Social Care

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Integrated Care System NI

## INTRODUCTION

1. As part of the development and implementation of the Integrated Care System for Northern Ireland, ICS NI, a Test Area Integrated Partnership Board (AIPB) was set up in the Southern Area.

2. The Test was limited to the local planning aspect of the wider ICS model in the form of Area Integrated Partnership Boards (AIPBs), and a set of anticipated outputs and success criteria were defined, and an evaluation strategy derived from those criteria to tie them to observation, assessment, and feedback channels.

3. This report aims at providing an overview of the key findings from the Test exercise, which commenced on 31 May 2023 and ran until 13 December 2023, and consisted of a total of eleven board meetings. Observations at those meetings, as well as feedback and comments from individual members, have been captured to enable a deeper understanding of the issues, and the successes, encountered.

## BACKGROUND AND CONTEXT

4. As part of a wider response to the challenges facing health and social care in Northen Ireland, ICS NI is being developed to provide the framework for planning, managing and delivering health and social care services in Northern Ireland, aimed at improving the health and wellbeing of our population and addressing demand by:

    - placing a focus on people keeping well in the first instance, providing timely, coordinated care when they are not, and supporting people to self-care when appropriate; and
    - ensuring we are maximising the resource we have available to deliver the best outcomes for our population, optimising our effectiveness and efficiency and reducing duplication.

5. Each Area Integrated Partnership Board (AIPB) will be a planning partnership for its geographical area, with responsibility for exercising the following functions:

    - identifying the health and social care needs of their local population (supported by a population needs assessment);
    - agreeing on the priorities from the identified need, aligned under a Strategic Outcomes Framework;
    - developing a plan to meet those needs; and
    - developing and providing recommendations on the distribution of available resources to meet those needs.

6. The Test activities in the Southern Area were aimed at enabling the programme team to further refine the design of AIPBs, understand the needs of the organisations and sectors involved, as well as supporting the establishment of strong foundations for integrated working and provide an environment to test key aspects of the model in practice.

7. The findings and lessons from the Test AIPB process will directly inform the final design of AIPBs as part of the ICS NI model, and, critically, their interaction and connectivity within the wider system, and will be incorporated within the implementation tasks going forward.

**TESTING FORMAT AND SUCCESS CRITERIA**

8. The purpose of the Test was to assess the group's ability to deliver on the aforementioned functions, and a series of seven anticipated Test outputs were initially defined within the strategy:

    - a clear understanding of the role of the AIPB and the role of individual members;
    - a clear understanding of the scope and remit of the AIPB;
    - an assessment of the proposed membership mix;
    - an assessment of robustness and adequacy of the supporting products and information;
    - informed Decision-Making Framework detailing how decisions will be made to provide clarity and transparency between the local levels;
    - the development of a viable action plan for the Southern Area, in line with agreed regional priorities; and
    - a clear indication of the supporting infrastructure required, both administrative and technical, with a particular focus on clarity on the roles and responsibilities of the Strategic Planning and Performance Group (SPPG) and Public Health Agency (PHA).

9. The capacity and ability of forming a partnership that would adhere to a common shared vision and develop trust and a mutual understanding to eventually deliver improved health and wellbeing outcomes for their local population was paramount. To this end, a set of Test success criteria was agreed, which included:

    - all members are clear on the role of the AIPB, their individual role within the AIPB and the linkages and benefits to their respective sectors/organisations;
    - all members agreed a shared vision for the Southern Area in line with strategic priorities;
    - ability of the Test AIPB to utilise the information and products provided to identify and agree key priority areas for focus from the current and emerging health and social care needs of the people in the Southern Area;
    - the Test AIPB being enabled to initiate the production of an informed, evidence-based action plan that would meet selected identified local needs in line with the restrictions imposed by the testing timelines; and
    - the Test AIPB developing and providing initial recommendations on potential redistribution of available resources to meet those needs in relation to the identified key priority areas.

10. Whilst this list was not exhaustive, it formed the basis of the evaluation process which was conducted.

## EVALUATION PROCESS

11. The progress of the Test AIPB was assessed against the success criteria outlined above through a variety of evaluation channels defined from the onset to collect and capture feedback and comments without directly interfering with the process. Those channels included:

    - member and co-chair survey and interviews;
    - observations from Mike Farrar, critical friend to the Test, supplemented by discussions with strategic partners and programme team colleagues; and
    - assessment of the product(s) delivered by the Test AIPB at the conclusion of the process.

### Member and Co-Chair Survey and Interviews

12. A survey was circulated at the conclusion of the two induction meetings, which provided some invaluable feedback on the content and format of these sessions.

13. Whilst the intention had been to circulate further surveys throughout the process, it was decided to focus on feedback interviews instead, which would provide a more detailed assessment of any potential issues and lessen the burden on members, given the time constraints and pressures associated with the process.

14. Interviews with members were organised in order to provide each of them with an open and transparent forum to express their views and own observations on the process, capture their insight on the successes, but more critically on the challenges and hurdles, that they've identified throughout, understand the root causes behind those and discuss ways to address them going forward.

15. Those interviews were carried out on a sector basis, and members were first given the opportunity to discuss their views after the initial eight meetings were completed, in the course of September and October 2023.

16. A series of follow-up sessions were scheduled in December 2023 and into January 2024 to capture further insight and reflexions and discuss some more specific aspects that had been raised throughout the interviews.

### Meeting Observations

17. Mike Farrar, who has extensive experience of working with Integrated Care Systems both across the UK and globally, attended most of the Test AIPB meetings in the capacity of critical friend to the Test, and provided the programme team with his views and observations, whilst also advising members and co-chairs, throughout the process.

18. His observations provided insight on the dynamics and cohesion amongst members and strategic partners, and their propensity to enable the partnership to produce and deliver as expected, but also on some of the difficulties and challenges encountered.

19. The SPPG and PHA strategic partners also attended all eleven meetings, and fed back to Mike Farrar and the programme team their perception of the dynamics and relations within the group, and the momentum displayed by members in understanding theirs and fellow members' roles and that of the AIPB, the characteristics and health needs of the local population, and identifying key priority areas accordingly.

**Product Assessment**

20. One of the key objectives was for the Test AIPB to define the outline of an informed, evidence-based action plan around would meet the identified needs of the local population around the key priorities identified by the group.

21. Acknowledging that this was a test environment with limiting timelines, it was agreed that the AIPB would focus on one key priority area – Frailty. This included getting a deeper understanding of the problems and gaps around frailty in the Southern area, as well as seeking expert advice and recommendations around potential actions for improvement.

22. Whilst significant progress has been made to date, the group did not have the time to produce a plan; however, a decision was made by the Test AIPB members, and approved by the ICS NI Steering Board, to enable the group to continue to progress this action plan until such a time as the shadow AIPBs are rolled out and established.

23. Consideration will therefore be given to the end product once finalised, and any findings and recommendations associated to the action plan will be discussed and considered going forward.

**TEST AIPB PROCESS**

24. The Test AIPB in the Southern Area commenced on 31 May 2023, with an initial schedule of eight meetings, and was then extended to December 2023. The membership was composed of 15 members, including both co-chairs: Dr Frances O'Hagan (LMC GP Representative) and Dr Maria O'Kane (Southern HSC Trust Chief Executive).

25. In total, the Test AIPB met on eleven occasions, both in person across locations within the Southern area and online. The approach to testing was articulated around four key phases which guided and framed the agenda, topics of interest and objectives of each of the meetings:

    - induction and understanding the roles of the AIPB, of each member and agree on a shared vision;
    - understanding the health and wellbeing needs of the local population through the provision of a population health needs assessment;
    - analysing the relevant data and information, identifying the gaps and key priority areas; and
    - reviewing potential actions that would improve local outcomes and developing a plan accordingly.

26. Those phases guided the agenda and purpose of each meeting, and Figure 1 below provides a summary overview of the timeline that was followed.

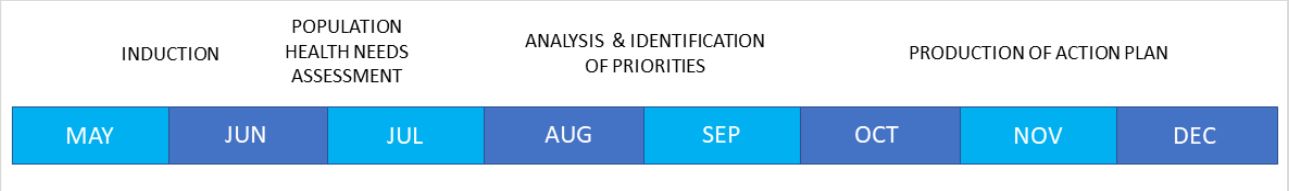


Figure 1 – Key Phases of the Test AIPB – 31/5/23 to 13/12/23

27. This timeline was quite restrictive and proved challenging, particularly due the high frequency of meetings. Even though the presentations on the agenda were pre-recorded and circulated ahead of each meeting, the capacity for members to fully review and ingest all the necessary information remained limited.

28. Moreover, it has not been possible to have a full complement of the core membership at any of the meetings. Nonetheless, the attendance of members has proven quite strong throughout, with at least one member from each of the key sectors participating at every meeting, with the exception of the 20 October session, when both the Service User and Carer representatives sent apologies.

29. This is testament of the ask on members in terms of time and capacity, but also of their commitment to this Test and to the ICS NI Programme as a whole. Figure 2 below provides a breakdown of the attendance throughout the process.

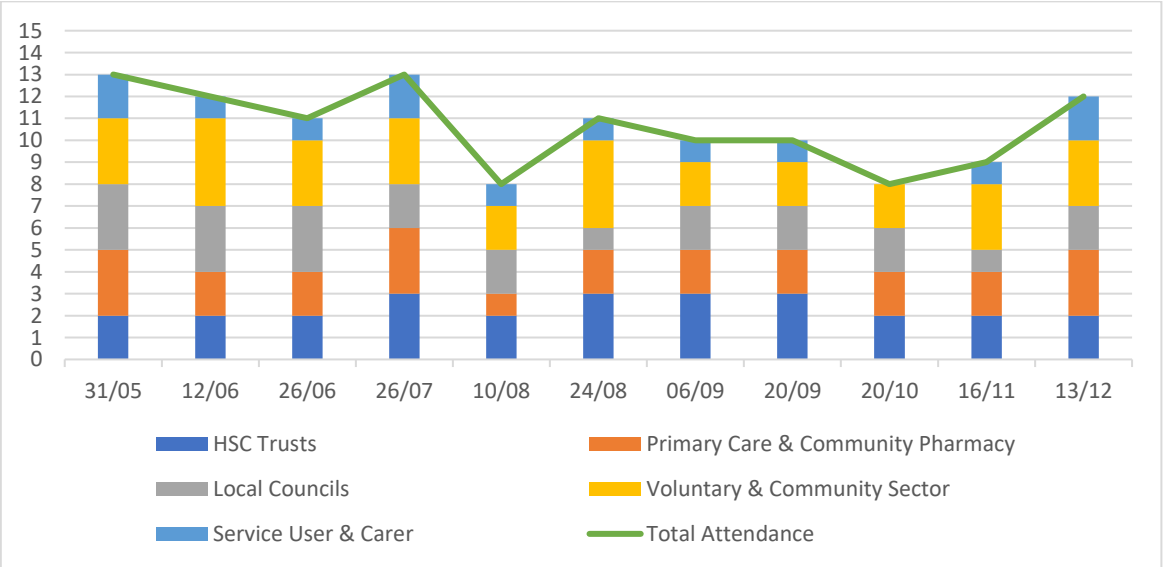


Figure 2 – Overview of attendance at the eleven Test AIPB meetings by sector – 31/5/23 to 13/12/23

30. The challenges associated with the burden and time commitment of being a member of an AIPB are currently being considered as part of the definition of the selection processes, and review of the sectoral role descriptions. Operating guidelines for AIPBs are also being developed that will fully incorporate the findings of this report in relation to the frequency of meetings and attendance amongst other aspects.

31. Finally, two designated strategic partners from SPPG and PHA provided all the necessary support to the Test AIPB and members individually. Beyond attending the Test AIPB meetings and providing their advice and guidance on request from the chairs and members, they set up a weekly meeting aimed at coordinating their support ahead of each meeting, with tasks including, but not limited to:

    - finalising the agenda of each meeting on the basis of the co-chair's direction and conclusions of the previous meeting;
    - assisting in completing the actions agreed at the previous meeting;
    - supporting the sourcing and analysing of relevant complementary data and information;
    - advising on different potential options to be considered by the board in relation to the key priority areas;
    - sourcing the relevant professionals and experts invited to present to the board.

32. The Test was an opportunity to understand the resource requirements relating to the business and strategic support, and further assessment work is currently ongoing in association with SPPG and PHA Senior Leadership.

## OVERVIEW OF KEY FINDINGS

33. The feedback and comments retrieved throughout the evaluation process were reconciled and analysed against the predefined anticipated Test outputs, acknowledging that the views and perceptions of each member may have evolved as the process developed.

34. The key findings from this process are summarised as follows:

    - the **importance of time and of investing in relationship-building** – the initial induction was well received in that respect, but a longer process would allow stronger foundations to be built;
    - the need for clarity on the **role of an AIPB and that of each member** – whilst those roles were defined ahead of the process and during the initial induction, it must be acknowledged that the developmental work continued during that time, and that those roles were not routinely revisited as the Test progressed, which may have caused a certain disconnect from members from what was originally set out;
    - the need to revisit **chairing arrangements** – whilst the two co-chairs of the Test AIPB were fully committed, concerns around the **burden and time commitment** involved were raised, and consideration for an independent chair or for the role to be open to the wider membership are two of the options currently under review;
    - the need for clarity around member **representativity**, in particular in relation to local council colleagues representing the Council, the Community Planning Partnership or both;
    - the importance of capitalising on **local knowledge and expertise**;
    - the clear understanding of the **role of SPPG and PHA strategic partners**;

- the tendency for meetings to **steer towards acute-focused issues**;
- the difficulty to identify priorities due to the width of the scope of an AIPB, and the resulting need for **overarching steer and guidance**;
- the difficulties associated with data, intelligence and analytical capabilities, particularly in relation to the population health needs assessment and the availability of **performance and financial information**; and
- the perception of the **role and aims of the AIPB throughout the wider system**, in particular when presenters were invited in relation to specific areas of expertise to give members a clearer understanding of the local picture, but instead set out to defend their position or pitched for funding.

35. The following section provides a more detailed overview of those key findings, balancing out the initial expectations of each of the Test outputs with a summary of the feedback and observations received, along with a set of recommendations that will inform the implementation work going forward.

## EVALUATION AGAINST ANTICIPATED TEST OUTPUTS

### Test Output 1: *A clear understanding of the role of the AIPB and the role of individual members*

Objectives

The aim of this output was to ensure that the definition of roles and objectives of the AIPB were clearly communicated and understood by each member, and more importantly that it was perceived to be the correct one in the context of a population health agenda focusing on prevention, early intervention and community health and wellbeing.

Another key aspect of this output was to ensure that each member had full clarity on their own role within the group, understanding the value they could bring to the partnership and portrayed themselves as an asset to the process. It was also about gaining a deeper understanding of the background and perception of fellow members in relation to their involvement with the AIPB.

From a Test perspective, this output aimed at defining the contours of the optimum role of an AIPB and its members.

Observations and Feedback

A member's pack, containing relevant background information as well as detailed role descriptions was provided to each member ahead of the first meeting, which was the first part of the induction process during which those roles and that of the AIPB were covered, and a shared vision was agreed by all.

However, it is acknowledged that the model remained under development and in fact was being continually refined, including as a direct consequence of this process, and this ultimately could have caused confusion. Moreover, the role and function of the AIPB and its individual members were not revisited throughout the process, and it may have been beneficial to instil this as a golden thread at each meeting to help maintain clarity of understanding and momentum.

There was also a lack of understanding that the membership in attendance from the onset was a core membership, and that members had the possibility, and were expected, to seek out the expertise of others within their organisations and/or wider sector when and where relevant. Likewise, some members were unclear on the role of the strategic partners, which led at times to scepticism on the role of SPPG and PHA in the process.

Ultimately, the process has shown that the establishment of an AIPB bringing those core partners together around the needs of the local population is undoubtedly of value, particularly in understanding the assets and resources which are available within that geography – a benefit that was repeatedly highlighted throughout the process. The Test has highlighted that the role of an AIPB within the population health agenda is very much grounded in community health and wellbeing.

*The view from the critical friend: There was a positive attitude towards the group which was compounded and build on in the group work where each attendee described their vision, providing a good platform on which to build.*

Recommendations

**Recommendation #1a: The role of the AIPB as a collective forum for improving community health and wellbeing utilising a population health approach is clearly articulated.**

**It is essential that effort and time be invested in each member to enable them to not only understand the role of the AIPB and their own role and value within the AIPB, but also fully**

**understand the views and perspectives of other members and thus develop trust and buy-in from the onset.**
**This will be a key component of the AIPB Induction programme, which will aim at providing relation-building opportunities as well as the necessary background knowledge.**

**Recommendation #1b: There is a need to fully clarify the role of the chair and that of the strategic partners for the benefit of all members. A separate induction process for chairs and strategic partners may be considered to ensure a strong working relationship is built and that there is a full understanding of their mutual roles and responsibilities within and outside the AIPB.**

**Recommendation #1c: The right support will need provided to members originating from outside the Health and Social Care sector, to ensure full clarity on their roles and responsibilities and enable the AIPB to capitalise on their local knowledge and expertise:**

- **Adequate support will need put in place from the onset so that Voluntary & Community Sector (VCS) members understand they are representative of the sector and are able to do so. Consideration will also need given to work currently being progressed by the Department for Communities in relation to potentially establishing VCS strategic partners within each Local Council.**
- **Local implementation will also focus on engaging with all local stakeholders and future partners to ensure full clarity on those roles and responsibilities ahead of roll out, with Service User and Carer representatives expected to advocate for Personal and Public Involvement within the AIPB.**

**Test Output 2:** ***A clear understanding of the scope and remit of the AIPB***

Objectives

This output was a direct extension of the previous one, and aimed at ensuring that members were fully aware of the scope and remit of the partnership in relation to the planning of health and social care for their local population, emphasising that the AIPB provided the mechanism that brought together a wide range of partners with a responsibility and/or interest in the health and care of the local population to take collective action for the benefit of that community.

From a Test perspective, it was about fully assessing the functions and responsibilities of the AIPB as a key component of ICS NI, and ensuring that partners were able to identify priorities and work together to tackle the challenges being faced in their local area, drawing their collective skills, resources and capabilities to develop plans that will deliver improved health and wellbeing outcomes, support sustainability and ultimately reduce health inequalities.

Observations and Feedback

As per the previous output, while this aspect was covered in the initial induction session, it was not revisited in the course of the process, which may have contributed to a certain loss of momentum. However, it became clear quite early on that the width and breadth of what was within the scope of an AIPB seemed slightly overwhelming for some members and subsequently led to what some viewed as an overly cumbersome process to distil areas of focus, pointing towards the need for additional steer and guidance to enable members to identify and agree local priorities.

Moreover, many members highlighted a certain tendency for the meetings to gear towards addressing acute-focused issues rather than people's health and wellbeing, and that the process failed to capitalise on the local knowledge and expertise that could be brought by some members with stronger links to the community.

The way the data was presented to AIPB members influenced the scope and direction of the group when identifying the key priorities and it is acknowledged that the AIPB was not provided with information and intelligence from some of the non-HSC members that would have informed their decision-making and subsequent planning.

*The view from the critical friend: The group self-assessment of whether they were clear on the role of the AIPB was encouraging, but it did not ascertain that all participants actually shared the same view about what that purpose actually is.*

Recommendations

**Recommendation #2a: The Regional ICS Partnership Forum should provide a mechanism for assuring clarity, focus and direction to AIPBs. Taking an approach such as NHS England's *Core20PLUS5* could help AIPBs in defining key priority areas that better reflect the needs of the local population and thus contribute to improving people's health and wellbeing and reducing health inequalities.**

**Recommendation #2b: The setting of planning assumptions will provide a focus which will enable all partners to identify and bring forth relevant information and intelligence in a timely manner, which will ultimately underpin the groups plan of action.**

**Test Output 3**: ***An assessment of the proposed membership mix***

Objectives

The aim of this output was to assess the proposed membership as defined within the ICS NI framework. This membership was designed to bring together a core of strategic leaders from within a local area. It was important that this membership be suitably representative of the various sectors, but equally important that it proved balanced and effective.

Whilst the proposed AIPB membership is broad, not every single aspect or area can be represented in a single group. It is expected that AIPBs, through their core membership, will engage directly with specific areas as required, be that through clinicians, professionals, organisations, local communities, collaboratives and networks, or other subject matter experts.

Each sector represented in the core membership is a unique asset in understanding the local population from different perspectives, providing insight on potential gaps in needs being addressed locally, or bringing the voice and experience of service users and carers to the fore and contribute to shaping the board's actions accordingly.

It is important to AIPBs that they can draw on the knowledge, experience and expertise of a broad range of clinicians, professionals, networks, organisations and other bodies when undertaking their work. AIPBs will engage and include such individuals and groups as required when discussing specific areas. They will draw on the existing infrastructure in their area to do this, as well as engaging with regional bodies, networks and service user and carer fora where they are established and as appropriate.

Observations and Feedback

The feedback from members was that the membership was well balanced, and that the presence of Voluntary and Community Sector colleagues, as well as Service User and Carer representatives was a real asset.

There were however some concerns in terms of specialist knowledge, with some members feeling that other colleagues would be better placed to deal with certain topics, and it was not clear to certain colleagues as to whether there was sufficient representation from sectors linked to wider social determinants of health, such as education. This resonated with the seemingly lack of understanding that this was a core membership, and that each member had the possibility to seek out the expertise of others within their organisations and/or wider sector.

The involvement of Local Council officers was also welcome, although there was some confusion as to what their optimum role was in terms of representation – were they representing the Council, the Community Planning Partnership, or both? The core membership for the Test AIPB included a council officer with responsibility/knowledge of community planning, and a key consideration of the Test has been to understand what design would best bring a link between both partnerships. It is now acknowledged that no one person can represent the Community Planning Partnership as a member of the AIPB and instead our focus should now be on a mechanism for alignment between the two bodies.

Many members voiced concerns around the burden and time commitment placed upon a Trust Chief Executive and a working GP as to whether they had the time to dedicate to the AIPB process. Moreover, some members felt that having two co-chairs from a Health and Social Care background led to a tendency for meetings to steer towards more acute-focused issues, and consideration should be given to wider sector members occupying the function. However, it should be noted that this was not as strongly observed by the critical friend to the Test. There was a common view that the Chair position should be open to all members which points to a lack of understanding that as per the ICS NI

Framework, the initial chairing arrangement proposed was to be reviewed after the first year of operation, to enable the positions to be more widely shared amongst the group.

The issue of representativity was raised in particular for VCS members around both having the mandate from the sector to sit on an AIPB and on the mechanism for enabling views of the wider sector to be gathered. An independent research report commissioned by the Department into these issues has led to an external organisation being appointed to undertake identification of VCS members to AIPBs, and work is ongoing both with the Strengthening Communities network and Community Planning Partnerships to identify existing infrastructure that could provide the required support mechanism.

*The view from the critical friend: The chairing arrangements are vital for the AIPB to work and whilst the Test AIPB had capable chairs, the fact that they both came from busy operational roles meant there was not always continuity of attendance and preparation. It was also noted that both Chairs had health service 'biomedical' experience which may have implicitly signalled an interest in a particular set of priorities. As it turned out, my reflection is that both Chairs supported the emphasis on prevention and earlier intervention, so the risk did not materialise.*
*However, I think it would be helpful to consider issuing guidance that allows for - a) appointing an independent chair b) assessing chairing skills before appointing the chair c) providing dedicated time for Chairs to prepare d) looking at whether a CP Chair could also chair the AIPB to ensure alignment between the two processes.*

Recommendations

**Recommendation #3a: Members should be made aware from the onset that the AIPB is made up of a core membership and that it will be the responsibility of each member to draw on the experience and expertise of others within their organisation or wider sector when and where it is needed. The AIPB Induction Programme will provide scrutiny to this aspect, whilst the Regional ICS Partnership Forum will ensure oversight functions that will encourage connections between different parts of the system and community.**

**Recommendation #3b: A mechanism is required to optimise the alignment between AIPBs and Community Planning Partnerships, and work should be progressed through the Community Planning Officers forum to bring forward a proposed solution.**

**Recommendation #3c: The chairing arrangements should be reviewed and an analysis of options, including retention of the status quo, should be conducted and brought to ICS NI Steering Board for consideration.**

**Recommendation #3d: Proposals to be brought forward to provide a support mechanism to enable Voluntary & Community Sector members to represent their sector – these should take account of the ongoing work by the CO3 Scope Study Project and DfC on their review of People and Place.**

**Test Output 4: *An assessment of robustness and adequacy of the supporting products and information***

Objectives

The aim of this output was to ensure that the products and information provided to the partnership were adequate and enabled members to get a full understanding of the characteristics of their local population, with the population health needs assessment provided by PHA colleagues at the centre of the considerations, along with relevant financial and performance information on existing services.

From a Test perspective, it was also an opportunity to assess the dynamics and logistics involved in the support function sourcing experts in the priority areas of focus and capturing their knowledge to enable members to further refine their understanding of the population and the identification of gaps, and plan actions accordingly.

*Observations and Feedback*

The population health needs assessment provided initially fell short of expectations and needed to be more focussed and detailed. PHA colleagues therefore reworked on this and designed a dashboard enabling members to have a more detailed picture of the local population.

There was also a lack of community data to complement the health data presented; this is a known issue from a Health and Social Care sector perspective, and it had been hoped that wider intelligence would be brought in from other partners within the group; however, this did not materialise.

The strategic partners also coordinated presentations from specialist colleagues in relation to the key priority areas. Those, however, needed to be more focused, and presenters given clarity on what they are presenting and the purpose of their presentation. There was a certain perception that presenters attending the meetings on the identified key priorities to inform and help the group better understand the local area picture of the existing actions and initiatives and identify potential gaps and shortcomings were instead in the optics of preserving their funding and protecting the services they were delivering or asking for resources/money to be diverted to their area.

Finally, Test timeline and pressures meant that performance and financial data on the identified key priority areas were not provided form the onset, and many felt this was detrimental to their capacity to get a full understanding of the current services picture within the area.

*The view from the critical friend: The public health data presented was still at a high level of abstraction, and it was emphasised that more detailed data would be needed to help the group to narrow down their emerging priority areas and enable them to focus on specific priorities and interventions.*

Recommendations

**Recommendation #4a: A detailed needs assessment should be provided to each of the AIPBs from the onset, with clarity around who should provide this information. This should be an immediate priority to provide members with the information they need to make informed decisions regarding key priorities in their areas.**
**While a needs assessment should be developed for each of the five AIPBs, as well as one at regional level, consideration should be given to the means of dissemination, e.g. in the form of an interactive dashboard.**

**Recommendation #4b: Whilst the provision of data and information from regional bodies will be essential, this should be complemented by wider intelligence from all partners, and the necessary data analytics support should be put in place to enable this. A comprehensive**

**engagement plan with wider stakeholders is currently being progressed and will aim at ensuring a full clarity of roles and functions going forward.**

**<u>Recommendation #4c</u>: The provision of adequate financial and performance information at the earliest opportunity will be essential, along with the identification of who is responsible for their production. This will enable AIPB members to gain a more detailed understanding of the local picture within their respective areas, in explaining the spending, investment and outcome of existing services, whilst highlighting gaps and underperforming areas.**
**The creation of multi-disciplinary planning teams within SPPG and PHA will act as an enabler to the provision of relevant service, performance and financial data associated with a priority area from an HSC perspective.**

**<u>Recommendation #4d</u>: Providing examples of good practice at regional and local levels alike will enable AIPB members to complement their understanding of the local picture and the definition of key priority areas. External contributors should be involved by invitation of the AIPB and facilitation of the strategic partners to deliver relevant presentations accordingly.**

**<u>Test Output 5</u>: *Informed Decision-Making Framework detailing how decisions will be made to provide clarity and transparency between the local levels.***

<u>Objectives</u>

This output aimed at assessing the dynamics of the group in discussing different options and making decisions around priorities, potential actions, or best delivery channels, accordingly, ensuring parity of esteem between members and providing a platform for each of them to express their views and bring their knowledge and expertise to the fore.

<u>Observations and Feedback</u>

It had originally been hoped that the skeleton of a decision-making framework would be designed as part of the process, however, time pressures did not make this possible. Consideration will be given to ensure this forms part of the AIPB induction programme.

Many decisions were taken by the group nonetheless, around the identification of key priority areas and the best avenues to pursue. However, some members observed that they were not clear as to how those decisions were made during meetings. It is acknowledged that the pressures imposed by the test environment may have contributed to decisions not being fully debated prior to being made to enable a diligent progression against the set timeline – which resulted in very busy agendas and very limited opportunities for discussions between meetings.

Some members indicated that not being from a clinical background also undermined their confidence to query or challenge Trust or Primary Care colleagues within the group, and overall, there was the feeling of a lack of parity of esteem across some sectors of the membership. Others observed that some colleagues were more passive than should or could have been, and lacked enthusiasm, or at least lost it as the process went on.

These pressures were also felt by the strategic partners who supported initially fortnightly meetings at pace throughout the process. A weekly preparation meeting was set up to that effect, aimed at coordinating their support ahead of each meeting, implementing the agreed actions, populating the following agenda agreed with the group, providing the relevant complementary analysis and information requested by members or sourcing and involving relevant expert colleagues to meet the needs of the process.

Whilst it was initially attended by the strategic partners and SPPG and PHA colleagues, and aimed at fulfilling its support function to the AIPB, it evolved into a wider group that incorporated invited Trust colleagues, mostly once the key priority areas were agreed, before morphing into a more operational plan implementation group once frailty became the key area of focus. Whilst its work was invaluable to the process, it should not have been a forum where planning decisions were made – which should have been the remit of the partnership board. Moreover, it was not representative of the membership, and some colleagues then had the impression that it became an alternative discrete decision-making forum from which they had been excluded.

*<u>The view from the critical friend</u>: One of the significant strengths of the AIPB is the full range of partners that sit round the table; the initial challenge was to establish the equality of voice and input between the partners and the AIPB rightly spent its two initial meetings establishing these ground rules and relationships.*

<u>Recommendations</u>

**<u>Recommendation #5a</u>: A decision-making framework needs to be put in place and agreed by AIPB members from the onset, at the induction stage or shortly thereafter. The AIPB should be responsible for this framework, however, it is expected that the Regional ICS Partnership Forum will inform the broader decision-making process and provide advice accordingly.**

**It will also be necessary to differentiate between normal meetings and decision-making meetings, to provide full clarity and transparency and set out the necessary parameters with relation to decisions, such as minimum attendance or distribution of represented sectors across attending members.**

**<u>Recommendation #5b</u>: While strategic partners will carry out support administrative, research and analytical work, any Task & Finish groups should be representative of the AIPB and led by one of the AIPB members, rather than strategic partners.**

**Test Output 6**: ***The development of a viable action plan for the Southern Area, in line with agreed regional priorities***

Objectives

This output aimed at assessing the capability of the group to produce an action plan based on their coming together as a partnership. With draft planning guidance and strategic direction, and broader advice from strategic partners was available from the onset, it was expected that the process would raise some useful pointers not only on the clarity of those products and functions, but also on the process followed to design and develop the plan.

Observations and Feedback

Whilst at the time of drafting this report the Board has not finalised its plan, agreement has been reached for the process to be extended to enable the Test AIPB members to continue their work until such a time that formal nominations and appointments are finalised and the AIPB is rolled out as shadow. The Board will therefore continue to build upon the progress made in relation to the Frailty key priority area and develop an action plan and proposal accordingly.

It is intended that feedback from the final development of the plan, its resourcing and implementation will be gathered and fed into the overall model.

Furthermore it should be noted that planning guidance, a bespoke induction programme, as well as the clear definition of the functions of the Regional ICS Partnership Forum (RICSPF) and roles of the strategic partners will allow for members to come together as a group and produce, as the partnership matures, an action plan for their respective areas, that will align with the overall strategic direction to the system.

Recommendations

**Recommendation #6a: The provision of the right data and information, such as the PHA dashboard, and additional and adequate analytical support will enable a more detailed description and identification of local need against the existing picture, thus enabling AIPB members to develop a plan accordingly.**

**Test Output 7: *A clear indication of the supporting infrastructure required, both administrative and technical, with a particular focus on clarity on the roles and responsibilities of SPPG and PHA***

Objectives

The aim of this output was to gain a clearer understanding of the roles and responsibilities of both SPPG and PHA in the context of AIPB activities, with a particular focus on the administrative, technical and analytical support functions.

SPPG will provide broader support to each AIPB through a strategic partner with experience and expertise in planning care and services. PHA will also provide a strategic partner to each AIPB for professional leadership and expertise in population health approaches and professional input.

Strategic partners will sit alongside the AIPB and offer guidance and support in the process of understanding the population's health and wellbeing needs, analysing the relevant data and information, and facilitating and securing advice and expertise from their respective organisations and the wider system, where and when AIPB members require such input to adequately develop plans.

Observations and Feedback

The SPPG and PHA strategic partners to the Test AIPB demonstrated a strong commitment to the process, despite a very challenging timeline. They offered their professional expertise and insight, and identified relevant professionals to come and contribute to the process and enable members to both:

- get a better understanding of the population needs through the work of PHA colleagues; and
- gain a deeper understanding of the key priority areas that had been selected.

There was however a lack of understanding from many members that SPPG & PHA colleagues attended AIPB meetings in their capacity as strategic partners, and that they were a resource to be utilised and relied upon. Confusion may have arisen from one of the nominated partners initially attending as a stand-in before fully joining the process, but more clarity should have been given to members and the strategic partners themselves as to their exact roles, functions and responsibilities ahead of and throughout the process.

*The view from the critical friend: as the AIPB was a test, the meetings were frequent in the initial months (meeting every other week); it quickly became apparent that meeting once a month would be more suitable once the AIPB had undertaken some initial 'relationship building'. Ensuring that all partners have the logistic capability and capacity to attend meetings and make their contributions is essential. The Test revealed how difficult it is, but essential, to ensure primary care colleagues can participate for example.*

Recommendations

**Recommendation #7a: As recommended above, it is essential that AIPB members are able to understand the point of view and roles of other members within and beyond the AIPB, but this also extends to the role and functions of the strategic partners from SPPG and PHA, for which job descriptions and a bespoke induction will be developed. It is expected that this will also form part of the overall AIPB Induction programme, while initial proposals with regards to the resource and grading requirements of the strategic partners are being reviewed.**

## CONCLUSION AND NEXT STEPS

36. The Test AIPB in the Southern area proved a very useful and insightful exercise in the context of the development and implementation of ICS NI, providing a positive outlook on the potential benefits that could be achieved in time through the adoption of integrated care and a population health approach to improving health and care outcomes.

37. The challenges and hurdles brought to light by the process, however, proved equally as invaluable, in that they have enabled the programme team to focus their attention on specific aspects which might not have otherwise been considered, or at such a level of detail. Addressing those points will contribute to a more seamless implementation of the shadow AIPBs, and more importantly place future members and support function colleagues and organisations in the best position possible to effect meaningful change.

38. The key findings listed in this report in the context of the anticipated Test outputs have led to the formulation of recommendations that will indeed be incorporated within the work of the implementation teams in the next few months. A comprehensive and tailored AIPB induction programme is being developed in association with the HSC Leadership Centre, which will aim at providing all the necessary background information to AIPB members. The programme will ensure that each member:

    - is able to clearly understand the context of the AIPB and ICS NI more widely;
    - understand their respective role within the AIPB and how they represent their organisation or sector;
    - realise how their responsibility to ensure adequate expertise from their sector is brought onboard as and when required; and
    - is able to understand the point of view and roles of other members within and beyond the AIPB, including the role and functions of the strategic partners from SPPG and PHA.

39. Wider engagement is also being progressed at both local and regional levels. This will aim at addressing the need to clarify the actual roles and objectives of the AIPB, and ICS NI as a whole, to the wider system to ensure any misunderstandings are avoided. It will also contribute to raise awareness with prospective members and their organisations/wider sector ahead of being nominated or applying for membership.

40. Evolved thinking on the role and functions of the Regional ICS Partnership Forum has led to the finalisation of its key primary objectives: Oversight of AIPB; Regional Collaboration; and Shared Learning Platform. In particular, its oversight functions will see AIPBs to be provided with a more detailed steer, enabling them to formulate planning assumptions that will set parameters within which to focus their attention, reflecting the priorities of all partners, especially around encouraging connections between different parts of the system and community.

41. A review of the chairing arrangements has also been initiated, first to address concerns around the burden and time commitment, but also in light of the potential benefits of having an independent chair or one originating from wider membership of the AIPB.

42. Finally, a review of the role of SPPG and PHA, and the creation of multi-disciplinary planning teams will act as an enabler to the provision of relevant service, performance and financial data associated with a priority area. In addition, a specific focus will be put onto reviewing the role and capacity of the support function from SPPG and PHA, in particular around the time and effort taken by our strategic partners in supplying the right support to AIPB members and co-chairs.