NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Board of the Integrated Care Board in PUBLIC

30 September 2022

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 30-09-2022
Time: 10:00 – 13:10
Venue: Milton Keynes Council Chamber, Civic Offices,
1 Saxon Gate East, Central Milton Keynes MK9 3EJ
Meeting: Board of the Integrated Care Board in Public

Agenda

No.	Agenda Item	Lead	Purpose	Time
Opening Actions				
1.	Welcome, Introductions and Apologies	Chair	-	10:00
2.	Relevant Persons Disclosure of Interests ▪ Register of Interests	Chair	Approve	
3.	Approval of Minutes and Matters Arising			
4.	Review of Action Tracker			
5.	Chair's Report (verbal)	Chair	Note	10:05
6.	Chief Executive Officer's Report	Chief Executive	Note	10:10
Strategy				
7.	System People and Workforce: ▪ People Plan ▪ Workforce Race Equality Standard ▪ Bitesize	Chief People Officer	Discuss	10:20
8.	Milton Keynes (MK) Together Health & Care Partnership – "MK Deal" update	Chief Executive & Chief Executive Milton Keynes Council	Note	10:35
9.	Digital Strategy	Chief Medical Officer	Approve	10:50
10.	Estates Utilisation Review	Chief Finance Officer	Note	11:05

No.	Agenda Item	Lead	Purpose	Time
Operational				
11.	Quality & Performance Statement	Chief Nursing Director & Chief of System Assurance and Corporate Services	Note	11:15
Break 11:30 (10 minutes)				
12.	Finance Report (July 2022 - Month 4)	Chief Finance Officer	Note	11:40
13.	Planning for Winter 2022-23	Interim Chief Transformation Officer	Note	11:50
14.	Local Maternity and Neonatal System Equity & Equality 5-Year Action Plan	Chief Nursing Director	Approve	12:00
Governance				
15.	NHS Bedfordshire, Luton & Milton Keynes Clinical Commissioning Group Annual Report & Accounts 2021/22	Chief Executive & Chief Finance Officer	Note	12:15
16.	Corporate Governance update: ▪ Terms of Reference for the Working with People and Communities Committee and Primary Care Commissioning and Assurance Committee ▪ Committee Membership ▪ Committee Chairs updates including Minutes ▪ Amendments to financial scheme of delegation ▪ NHS England Constitution amendments	Chief of System Assurance and Corporate Services & Committee Chairs	Approve	12:25
17.	Annual Cycle of Business	Chair	Discuss	12:35
18.	Communications from the meeting	Chair	Discuss	12:40
19.	Questions from the public	Chair	Discuss	12:45
20.	Review of meeting effectiveness: a) Was the quality of the papers sufficient to allow you to discharge your duties and the expectations of each paper?	Chair	Discuss	12:55

No.	Agenda Item	Lead	Purpose	Time
Closing Actions				
21.	Any Other Business	Chair	-	13:05
22.	Date and time of next meetings: **Board Development Session** 10:00 – 16:00, Friday 4 November 2022 Central Bedfordshire Council, Priory House, Chicksands, Shefford, Bedfordshire SG17 5TQ **Board of the Integrated Care Board** 10:00 – 16:00, Friday 25 November 2022 Luton Council, Council Chamber, Town Hall, Luton LU1 2BQ Deadline for reports will be: Noon on Tuesday 15 November 2022	Chair	-	13:10

Resolution to exclude members of the press and public

The Board of the Integrated Care Board resolves that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest, Section 1(2), Public Bodies (Admission to Meetings) Act 1960.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
2. Relevant Persons Disclosure of Interests

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☐	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☐	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☐	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☐	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☐	Ways of working ☐	Estates ☐
Communications ☐	Finance ☐	Operational and Clinical Excellence ☐	Governance and Compliance ☒
Other ☐ (please advise):			

What are the members being asked to do?		
Approve ☒	Note ☐	Discuss ☐

Report Author	Governance and Compliance Team
Date to which the information this report is based on was accurate	13 September 2022
Senior Responsible Owner	Chair of the meeting

Executive summary

What is a conflict of interest?

A conflict of interest occurs where your ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest you hold. Conflicts of interest are inevitable, and it is how we manage them that matters.

Disclosures of interest should be made as soon as reasonably practicable and by law within 28 days after the interest arises (this could include an interest an individual is pursuing).

Further opportunities to make declarations include on application, on appointment, at meetings, when prompted to do so by the organisation or, on change of role.

What are the rules on Gifts and Hospitality?

- Never accept cash of any amount.
- You may accept promotional aids worth less than £6, even from suppliers / contractors.
- Gifts under £50 may be accepted, but not from suppliers / contractors (unless a promotional aid under £6).
- Gifts over £50 must be treated with caution and only accepted on behalf of an organisation, not an individual.
- Meals / refreshments under £75 may be accepted, except if they go beyond what the organisation might offer but offers from a supplier / contractor need particular caution and Executive Director approval.
- Offers of foreign travel and accommodation - offers of hospitality, including offers of foreign travel, that go beyond what the organisation might offer should be politely declined.

What are the available options?

To maintain accurate entries on the Registers of Interests

Recommendation/s

Members are asked to:

- Review the Register of Interests [Appendix A] and confirm their entry is accurate and up to date.

All in attendance are asked to:

- Confirm that all offers of Gifts and Hospitality received in the last 28 days have been registered with the Governance & Compliance team via blmkicb.corporatesec@nhs.net
- Declare any relevant interests relating to matters on the Agenda.

Key Risks and Issues

There are none identified.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

This is not applicable in this circumstance.

Are there any financial implications or other resourcing implications?
There are none identified.
How will / does this work help to address the Green Plan Commitments? Click to view Green Plan
This is not applicable in this circumstance.
How will / does this work help to address inequalities?
This is not applicable in this circumstance.
The following individuals were consulted and involved in the development of this report:
Governance & Compliance Team
Next steps:
Should an individual declare an interest relating to items on the agenda, the minutes must include: 1. Individual declaring the interest. 2. At what point the interest was declared. 3. The nature of the interest (see descriptions below). 4. The Chair's decision and resulting action taken (i.e., will be required to leave the meeting for the item, can stay for the item but not involved in decision-making, etc.) If applicable, the point during the meeting at which any individual/s retired from and returned to the meeting to be captured under the relevant agenda item: Start of item: xx left the meeting as agreed under item 2. - End of item: xx returned to the meeting. Following the meeting the Secretariat must forward a Declaration of Interest form to the individual to complete and return. The Register of Interests will then be updated by the Governance & Compliance Team.
Appendices
Appendix A – Register of Interests

Type	Description
Financial Interests	This is where an individual may get direct financial benefits from the consequences of a decision.
Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a decision, such as increasing their professional reputation or status or promoting their professional career.
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit.
Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a decision.

Appendix A

ICB Register of conflicts of Interest - Members and Participants - 13.9.22

				Type of Interest								
Surname	**Forename**	**Position within, or relationship with the ICB**	**Interests to Declare**	**Financial Interest**	**Non-Financial Professional**	**Non-Financial Personal**	**Indirect**	**Description of Interest**	**Date From**	**Date To**	**Actions to be taken to mitigate risk**	**Date Declared**
Alsop	Richard	Interim Chief Transformation Officer	Yes	Y				I am a 50% shareholding director of FACT Solutions UK Ltd, which provides professional services, including PR, communications and marketing services to public and private sector clients. The company has no contracts with health & social care clients currently. My partner, Katharine Alsop is the other 50% shareholding director of FACT Solutions UK Ltd	2014	Ongoing	Will not bid for work in BLMK / Declare in line with conflicts of interest policy	21/06/2022
Alsop	Richard	Interim Chief Transformation Officer	Yes			Y		I am a Non-Executive Director (Board Safeguarding Lead) for the Northamptonshire Football Association	2021	Ongoing	Declare in line with conflicts of interest policy	21/06/2022
Blakeman	Andrew	Non Executive Member, Chair Audit & Risk Assurance Committee	No	N	N	N	N	Director, STRYDE International Ltd, a subsidiary of BP plc, Chertsey Rd, Sunbury-on-Thames, TW16 7BP, and previous directorships within the BP Group	01/01/1996	Ongoing	This is not a conflict of interest and requires no mitigation. However, most COI registers require all directorships of private companies to be declared.	15/06/2022
Borrett	Alison	Non Executive Member	No									21/06/2022
Bracey	Michael	Chief Executive, Milton Keynes Council	No									11/05/2022
Carter	David	Chief Executive, Bedfordshire Hospitals Foundation Trust	Yes	Y				Chief Executive of Bedfordshire Hospitals NHS Foundation Trust	08/05/2017	Ongoing	Needs completion	18/05/2022
Carter	David	Chief Executive, Bedfordshire Hospitals Foundation Trust	Yes				Y	Wife employed by NHS England Eastern Region	2019	ongoing	Needs completion	18/05/2022
Cartwright	Sally	Public Health Representative, Luton	No									22/06/2022
Church	Laura	Chief Executive, Bedford Borough Council	Yes	Y				Bedford Borough Council, Commissioner of Public Health and Social Care Functions	05/10/2021	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
Church	Laura	Chief Executive, Bedford Borough Council	Yes		Y			East of England Local Government Association - Chief Executive lead on health inequalities	01/12/2021	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
Church	Laura	Chief Executive, Bedford Borough Council	Yes				Y	Ian Turner (husband) provides consultancy services to businesses providing weighing and measuring equipment to the NHS	05/10/2021	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
Coiffait	Marcel	Chief Executive, Central Bedfordshire Council	Yes	Y				I am the Chief Executive of Central Bedfordshire Council which is an may be commissioned to work on behalf of the ICB	01/11/2020	Ongoing	Needs completion	27/05/2022

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Cox	Felicity	Chief Executive	Yes		Y			I am a registered pharmacist with the GPC (General Pharmaceutical Council) and a member of the Royal Pharmaceutical Society	17/08/1987	Ongoing	I will excuse myself should an interest arise	14/06/2022
Davies	Geraint	Interim Chief of System Assurance & Corporate Services	No									28/06/2022
Graves	Stuart Ross	Exec Director CNWL	No									20/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Interim Chair, University of Birmingham	Apr-22	Ongoing	Needs completion	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Vice Chair NHS Employers Policy Board	2021	Ongoing	Needs completion	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Trustee of NHS Conferation	2021	Ongoing	Needs completion	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Council Member - National Association of Primary Care	2020	Ongoing	Needs completion	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				Keele University - Lecturer	2016	Ongoing	Needs completion	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				Advisor to Alphasights, MM3 Global Research, Silverlight and Stepcare	2018	Ongoing	Needs completion	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Chair, CRN Thames Valley & South Midlands Partnership Group Meeting		Ongoing	Needs completion	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Member, Oxford AHSN		Ongoing	Needs completion	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes				Y	Spouse, Samantha Jones, is the Permanent Secretary and COO for No 10 Downing Street	Mar-22	Ongoing	Needs completion	16/05/2022
Head	Vicky	Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes.	No									27/06/2022
Kufeji	Omotayo	GP, Primary Services Partner Member	Yes		Y			Director of Clinical Transformation, BLMK CCG	04/08/2020	30/06/2022	Role ended N/A	29/07/2022
Kufeji	Omotayo	GP, Primary Services Partner Member	Yes		Y			The Bridge PCN Clnical Director	01/04/2021	31/03/2023	Exclusion from direct decisions affecting PCNs	11/05/2022
Kufeji	Omotayo	GP, Primary Services Partner Member	Yes		Y			Member, NHS Confederation Primary Care Network	07/07/2019	Current	Exclusion from direct decisions affecting PCNs	08/09/2022
Kufeji	Omotayo	GP, Primary Services Partner Member	Yes		Y			Member, National Association of Primary Care (NAPC) Council	01/10/2020	Current	Exclusion from direct decisions affecting PCNs	08/09/2022
Makarem	Rima	Chair	Yes		Y			Chair of Sue Ryder (non remunerated)	01/05/2021	Ongoing	Declare in line with conflicts of interest policy	17/06/2022
Makarem	Rima	Chair	Yes	Y				Chair of Queen Square Enterprises Ltd (remunerated)	01/11/2020	Ongoing	Declare in line with conflicts of interest policy	17/06/2022

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Makarem	Rima	Chair	Yes	Y				Lay Member of General Pharmaceutical Council	Apr-19	Ongoing	Declare in line with conflicts of interest policy	17/06/2022
Mattis	Lorraine	Associate Non Executive Member	Yes	Y				Director - Community Dental Services CIC	Nov-19	Ongoing	Declared in line with conflicts of interest policy	09/09/2022
Murray	Anne	Interim Chief Nursing Officer	No									22/06/2022
Pointer	Shirley	Non-Executive Member, Chair Remuneration Committee	No									15/06/2022
Porter	Robin	Chief Executive, Luton Borough Council	No									17/05/2022
Poulain	Nicky	Chief Primary Care Officer	No					New Vista Homes				30/06/2022
Roberts	Martha	Interim Chief People Officer	No									04/07/2022
Shah	Mahesh	Partner Member	Yes	Y				AP Sampson Ltd t/a The Mall Pharmacy, Unit 3, 46-48 George Street, Luton LU1 2AZ, co no 00435961, community pharmacy	Nov-88	Ongoing	Needs completion	20/05/2022
Shah	Mahesh	Partner Member	Yes				Y	RightPharm Ltd, 60a Station Road, North Harrow, HA2 7SL, co no 08552235, community pharcy, son & sisters	28/03/2014	Ongoing	Needs completion	20/05/2022
Shah	Mahesh	Partner Member	Yes				Y	Calverton Pharmacy Ltd, 62 Calverton Rd, Luton LU3 2SZ, co no 07203442, community pharmacy, son & sisters	03/04/2018	Ongoing	Needs completion	20/05/2022
Shah	Mahesh	Partner Member	Yes				Y	Gamlingay Pharmacy Ltd, 60a Sation road, North Harrow, HA2 7SL, no no 05467439, son & sisters	01/04/2021	Ongoing	Needs completion	20/05/2022
Shah	Mahesh	Partner Member	Yes		Y			Committee Member, Bedfordshire Local Pharmaceutical Committee	1984	Ongoing	Needs completion	20/05/2022
Shah	Mahesh	Partner Member	Yes		Y			Community Pharmacy PCN Lead, Oasis PCN, Luton	06/02/2020	Ongoing	Needs completion	20/05/2022
Stanley	Sarah	Chief Nurse Director	No									08/09/2022
Stock	Tracey						Y	Member of the East London Foundation Trust (ELFT) Council of Governors	15/12/2021	01/05/2023		05/07/2022
Taffetani	Maxine	Healthwatch Representative for Bedfordshire, Luton and Milton Keynes	No									22/06/2022

				Type of Interest								
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Westcott	Dean	Chief Financial Officer	Yes				Y	Wife is Senior Mental Health Transformation Manager at West Essex CCB	01/06/21 on joining CCG	Ongoing	Email 15/6/22 - "Should there be any Mental Health links with West Essex (unlikely)I would of course withdraw from any discussions/decision making	14/06/2022
Westcott	Dean	Chief Financial Officer	Yes		Y			Chair of Board of Trustees - Association of Chartered Certified Accountants Pension Scheme	01/06/2021 on joining CCG	Ongoing	Email 15/6/22 - "The Acca interest is completely outside of the NHS and will finish at the year end in any event"	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes				Y	Civil partner, Advanced Nurse Practitioner (Walnut Tree Health Centre, Milton Keynes)	2010	Ongoing	To be addressed as required	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes		Y			Stonedean, Practice - Former Partners and current sessional GP	01/06/2007	Ongoing	To be addressed as required	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes	Y				GMC (General Medical Council – Associate – Assessor medical performance	2012	Ongoing	To be addressed as required	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes	Y				AKESO (coaching network) – coach – Executive and Performance Coach	01/02/2020	Ongoing	To be addressed as required	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes	Y				NHSE – Appraiser (Summative & Formative discussions)	2010	Ongoing	To be addressed as required	14/06/2022
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes	Y				I am a Non-Executive Director and Deputy Chair of Northamptonshire Healthcare NHS Foundation Trust, St Mary's Hospital, London Road, Kettering NN15 7PW. NHFT provide prison health services to Yarlswood Immigration Removal Centre and Bedford Prison in BLMK. These services are not commissioned by BLMK ICB.	Nov-18	Ongoing	Exclusion from involvement in related meeting or d	14/07/2022
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes	Y				I am Chair of Trustees for Arts for Health MK a registered charity that is responsible for the art collection at MK University Hospital NHS Trust and provides art on prescription for MK residents. Address MK University Hospital, Standing Way, Eaglestone, Milton Keynes MK6 5LD	2010	30/09/2022	Will be declared as relevant in meetings and will not be involved in any funding or other decisions where Arts for Health MK may be a beneficiary. Standing down from role by 30/09/22.	14/07/2022
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes			Y		I am a member of Inspiring Futures Through Learning Multi-Academy Trust which covers schools in MK and Northamptonshire. Address: Fairfields Primary School, Apollo Avenues, Fairfields, Milton Keynes MK11 4BA	2016	Ongoing	Will be declared in any relevant meetings.	14/07/2022

				Type of Interest								
Surname	**Forename**	**Position within, or relationship with the ICB**	**Interests to Declare**	**Financial Interest**	**Non-Financial Professional**	**Non-Financial Personal**	**Indirect**	**Description of Interest**	**Date From**	**Date To**	**Actions to be taken to mitigate risk**	**Date Declared**
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes	Y				I am a Director of Netherby Network Limited which is a consultancy company that has provided services to MK CCG in the past. It does not currently provide any services for health or care clients. Address: 69 Midland Road, Olney, MK46 4BP	Mar-14	Ongoing	No actions required as the company is not trading.	14/07/2022
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes				Y	Daughter, Eilis Humberstone, registered on the CNWL staff bank	11/07/2022	Ongoing	No further action required. My daughter holds a temporary admin role for summer 2022	14/07/2022

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
3. Approval of Minutes

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☐	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☐	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☐	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☐	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☐	Ways of working ☐	Estates ☐
Communications ☐	Finance ☐	Operational and Clinical Excellence ☐	Governance and Compliance ☒
Other ☐ (please advise):			

What are the members being asked to do?		
Approve ☒	Note ☐	Discuss ☐

Report Author	Secretariat
Date to which the information this report is based on was accurate	13 September 2022
Senior Responsible Owner	Chair of the Committee

Executive summary
The purpose of this paper is to review the Draft Minutes from the meeting held on 29 July 2022 with a view to their approval.
What are the available options?
To approve the minutes or to approve them subject to any required amendments.
Recommendation/s
The members are asked to **approve** the Draft Minutes.
Key Risks and Issues
There are none identified.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

There are none identified.
Are there any financial implications or other resourcing implications?
There are none identified.
How will / does this work help to address the Green Plan Commitments? Click to view Green Plan
This is not applicable in this circumstance.
How will / does this work help to address inequalities?
This is not applicable in this circumstance.
The following individuals were consulted and involved in the development of this report:
The Committee Chair.
Next steps:
The Secretariat will finalise minutes e.g., make required amendments and save as approved.
Appendices
Appendix A – Draft Minutes

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 29 July 2022

Time: 10.00 – 12.30, *finished at 12.54*

Venue: Central Beds. Council, Priory House, Chicksands, Shefford, Beds S17 5TQ

Minutes of the: Board of the Integrated Care Board (ICB) **in PUBLIC**

Members:		
Andrew Blakeman	Non-Executive Member	AnBl
Alison Borrett	Non-Executive Member (*arrived 10.47)*	AlBo
David Carter	Partner Member, NHS Trusts and Foundation Trusts	DC
Laura Church	Partner Member, Local Authorities	LC
Felicity Cox	Chief Executive	FC
Ross Graves	Partner Member, NHS Trusts and Foundation Trusts	RG
Joe Harrison	Partner Member, NHS Trusts and Foundation Trusts	JH
Dr Omotayo Kufeji	Partner Member, Primary Medical Services	OK
Dr Rima Makarem (Chair)	Chair	RM
Anne Murray	Interim Chief Nursing Director	AM
Shirley Pointer	Non-Executive Member	SP
Robin Porter	Partner Member, Local Authorities	RP
Dr Mahesh Shah	Partner Member, Primary Medical Services	MS
Dean Westcott	Chief Finance Officer	DW
Dr Sarah Whiteman	Chief Medical Director	SW
Participants:		
Richard Alsop	Interim Chief Transformation Officer	RA
Vicky Head	Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes Councils	VH
Martha Roberts	Chief People Officer	MR

In attendance:		
Kim Atkin	Committee, Governance & Compliance Officer (Minutes)	KA
Anne Brierley	*Incoming* Chief Transformation Officer	AnBr
Sarah Feal	Head of Governance	SF

Gaynor Flynn	Governance & Compliance Manager	GF
Ian Perrin	Policy & Delivery Manager, NHS Confederation (observing)	IP

Apologies:		
Michael Bracey	Partner Member, Local Authorities	MB
Sally Cartwright	Interim Director of Public Health, Luton	SC
Marcel Coiffait	Partner Member, Local Authorities	MC
Nicky Poulain	Chief Primary Care Officer	NP
Maxine Taffetani	Chief Executive Officer, Healthwatch, Milton Keynes – representing all local Healthwatch within BLMK	MT
Maria Wogan	Chief of System Assurance & Corporate Services	MW

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed all present to this meeting of the Board of the Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB) held in Public. All ICB members, participants and attendees introduced themselves. Apologies were **noted** as above. Ian Perrin, Policy & Delivery Manager, NHS Confederation was welcomed to the meeting as an observer. The Chair welcomed Lorraine Mattis, who will shortly be joining the ICB as Associate Non-Executive Member. A fourth Non-Executive Member will also be announced soon. It was **confirmed** that the meeting was quorate. The meeting was being recorded for the purpose of the minutes and a photographer was present for corporate purposes.	
2.	**Declarations of Interest – Register of Members' Interests** Members had reviewed the Register of Interests and **confirmed** that entries were accurate and up to date, with the exception of: • Dr Omotayo Kufeji advised that his interest at the CCG had now ceased; and • David Carter stated that his work at Bedfordshire Hospital Trust was not voluntary. **Action**: KA to confirm changes in writing and update Register. It was **noted** that attendees were asked to confirm that any offers of gift or hospitality received in the last 28 days, in relation to ICB business, have been	KA

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	registered with the Governance & Compliance Team. No submissions had been made. **No conflict of interests were declared** in relation to matters on the agenda.	
3.	**Approval of Minutes and Matters Arising** The Board confirmed its **agreement** that the minutes were a full and accurate record of the meeting. There were no matters arising that did not form part of today's agenda.	
4.	**Review of Action Tracker** An updated action tracker had been circulated, which comprised four items, all of which were proposed to close. It was **agreed** to close items 1-4 on the action tracker. **Action**: KA to update action tracker for closed items. It was clarified that the version of the 100 Day Plan that had been shared was the internal ICB version and that a public-facing version will be circulated more widely which will highlight the public milestones. **Action**: Public-facing version of 100 plan to be circulated widely and made available online – Jane Meggitt. It was further confirmed that the Internal Strategic Place Leads will be appointed within the 60 day timeframe to 29 August, and that local strategic place leads will be appointed at the discretion of the Place Boards.	KA J Meggitt
5.	**Chair's Report** A key item on the agenda today is the Integrated Care Strategy, which will set the scene around what strategy means for the ICB and where it is being developed, with NHS organisations and the four Local Authorities working together to determine the strategies to follow for our population's health. The ICB will need to respond to that strategy. Where and how items of strategy will be delivered will need to be addressed. A response to the Fuller response will need to be put in place which will be discussed later in the agenda.	
6.	**Chief Executive's Report** There has been much work to get the mechanics in place for the new organisation. The new, almost complete, Executive Team has met for the first time and there are already helpful discussions as to identifying 2-3 key themes for action with initial thoughts including over-medicalisation and over-treatment and pressure on services. Any significant proposals for change will come to the Board for discussion and assessment.	

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	The ICP strategy, to be discussed later, will define cohorts of the population where we want to focus on improving population health: the joint forward plan will be the response to that strategy. The joint forward plan will look at how to balance medical optimisation, health change and the medical challenges that our population is facing, but it must also meet the needs of the NHS and of the ICB. Some of the key challenges for our population are urgent and emergency care, access to GPs, elective waiting lists, the cancer backlog and health inequalities. At the first ICB System Oversight and Assurance Group (SOAG), the issue of peer accountability across the ICS and making sure that there is both system and self-assurance through all the work of the ICS was raised, so that SOAG is only concerned with areas that are challenging the whole system or that are not improving and need further support. The Chief Executive will be taking this forward with the system leader and CEO Group. **Action**: FC to take forward peer accountability across the system at SOAG and CEO Groups.	FC
7.	**Resident's Story** The Chair shared the Board's intention to hear one "resident's story" at each meeting, and to understand where residents are getting lost in the system, to inform our discussions and planning. It was considered that Healthwatch would have a different level of transparency and would be able to bring interesting patient stories to the table. Front line, clinical staff and local authorities will bring other perspectives. This would not be a forum for individual patient concerns or complaints, but for looking at failings in the system and working together to address these. It is important to demonstrate co-production to achieve desired outcomes rather than concentrate on individual stories. It is also important to hear voices of those less represented in society, for example Afghan refugees who are struggling to access services. It was suggested possibly commissioning the Healthwatch organisations to engage with members of the public. It was further suggested that the "Resident's Story" item be tabled later in the agenda. **Action:** MW to take forward for next meeting.	M Wogan / KA
8.	**Integrated Care Strategy** The Interim CTO introduced the paper which sets out how Bedfordshire, Luton and Milton Keynes Integrated Care System (BLMK ICS) plans to develop our system strategy and forward plan and the role of ICB partners in supporting this. This strategy will be owned by the BLMK Health & Care Partnership (H&CP), our name for the Integrated Care Partnership (ICP) and will be developed with partners over the next few months and published in December 2022. It will describe how the health and care needs of the local population are to be met over the next 10-20 years.	

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	Development of this strategy will be co-ordinated by the ICB strategy and planning team on behalf of the H&CP. The strategy will build on existing strategies at place and our existing system ambitions developed in response to the Long Term Plan. There is already a strong platform to build on and conversations will also focus on developing our resources and taking forward and developing the joint plan. The Health and Care Act 2022 requires ICBs and their partner NHS trusts and foundation trusts to prepare a plan, an "Integrated Care (or "Joint Forward") Plan, setting out how they propose to exercise their functions over the next five years. Guidance, setting out the principles and legislative framework, will be published soon. The plan will include a focus on services delivered by NHS organisations, but in order to properly reflect our place focus, would want to include relevant local authority services, as well as other partners and voluntary services if practical within this timescale. The Plan will be owned by the ICB and will be called the "ICB Joint Forward Plan". The plan will evolve and will focus on key areas where we can make a difference. Some parts may be aspirational and may not have gone through all governance processes. LC highlighted that Local Authorities would need the time to take some topics through their own governance processes, as appropriate. The Chair asked that once guidance has been received, the template be pre-populated with our known high level strategic priorities and local plans that are already in place. We can then identify the scale of gaps and consider what needs to be done in the short-term to December to enable us to appropriately complete the template, but without comprising our discussions or the granularity of what we are trying to deliver. There was a robust discussion which included caution around too much time being spent on strategy and not on implementation – must deliver while the strategy continues to evolve and the importance of sharing what is already working well and building on that. It was suggested to add the word "happier" to our mission statement. **Action**: Strategy Team to prepopulate the strategy from existing work and to consider adding the word "happier" to our mission statement. The Chair told the members that there will be a deep dive into Children & Young People at the H&CP, to identify which target groups to work on. A proposal will then be pulled together and brought into the Plan. A similar process will follow for other priority areas. **Action**: Outcome from Children & Young People deep dive to be brought to ICB on 30 September. The Board's **recommended approach** is to aspire for the ICB Joint Forward Plan to be as broad as possible but acknowledging that it will need to build over time. The Board **agreed** that a task and finish group be established to oversee the development of the Joint Forward Plan – comprising members from across the system planning architecture – membership to also reflect the decision about the breadth of the approach.	~~RA~~ RM / TS

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	All **partners are requested** to identify existing local strategies and plans beyond the Health and Wellbeing Board Strategies which should form the basis of our integrated care strategy by 8 August 2022. All **partners are requested** to identify relevant boards to discuss the development of the Health and Care Partnership strategy and set the foundation for the system Joint Forward Plan by 8 August 2022 **Action**: On page 37, RA to include Place strategies. **Action**: All partners to contact RA in relation to existing local strategies and plans beyond Health and Wellbeing Board Strategies **Action**: All partners to identify relevant Boards to discuss the development of the H&CP strategy and set the foundation for the system Joint Forward Plan by 8 August 2022 **Action**: RA to report back on Task & Finish Group to next meeting of the Board of the ICB.	RA All All RA
9.	**Next Steps for Integrating Primary Care – Fuller Stocktake** Taking the report as read, the Chief Executive highlighted the following: - The Fuller report underlines the importance of Place; - There is a step-change in ambitions for Preventative Care - working with not only local groups, but also local authorities and the voluntary care sector, as well as the entire Primary Care network, including community pharmacy, optometry and dentistry; - A streamlining of Urgent and Episodic Care, looking at a single 24/7 point of coordination; - Flexibility to offer virtual or face to face options in line with patient preference and need; **A Borrett arrived at 10.47** - Secondary prevention driven by proactive management of chronic disease, to prevent deterioration in health and prolong healthy life expectancy through review of disease registers; - Enabling and supporting people to manage their own long-term conditions; and - Named clinician care coordinator working alongside patients and families to ensure timely access to holistic care and minimise time spent in hospital. Some of the building blocks are already in place, such as the move to multi-disciplinary meetings for those with diabetes, which demonstrates the value of secondary care consultants working within primary care. The Fuller Neighbourhood Teams are challenging us all to work more closely with residents' associations, schools and other local organisations who have more local expertise. The Fire and Police services have already expressed interests in being more involved at a local level. ***Discussion***	

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	- It is important to build on the work that Primary Care Networks (PCNs) are already doing, so that in time they will be one and the same as Fuller Neighbourhood Teams; - We need to keep the language simple and not confuse PCNs; - Geographical challenges should not be a block; - This work needs to be a priority but will need further support; - Need to be mindful that there is also a shortage of pharmacists; - Having a fit for purpose estate will be important – Capital and Estates Oversight Group has started a review of current estate and what opportunities there are across the public estate; - There needs to be a Capital Funding Strategy not just for the NHS but for Primary Care; - Transformation Fund support, which assisted estates and technology in Primary Care, has stopped and there is no replacement; - People in communities are keen to share resource, empty retail buildings could be used, there are often these discussions in Health and Wellbeing Board meetings, need to be creative; - Data and workforce are the elephants in the room; - Differences between a PCN and NHS Trust employment methods– if they were aligned it would help workforce challenges and be easier to integrate management across different workforces; - Better communication with the public on how to access appropriate services is key; - Messages need to be simple and prioritised as to what would give most impact to the population; and - The Grove Central Hub in Dunstable will give Primary Care at scale – social care, mental health, community and voluntary services all available in one building. Hoping to achieve 7-day appointments, but this cannot be achieved without scale. Primary Care Networks (PCNs) will be encouraged to work more closely with local organisations to collectively support the population's health and wellbeing needs. As they evolve, they will effectively become Fuller Neighbourhood Enabler Teams, although currently not all PCNs are configured around neighbourhoods. The Board **noted** the report and the Fuller Review and **approved** the proposed approach to implementation. It was **agreed** that a quarterly update on implementation would be brought to the Board. The Board **noted** that a review of Estates was taking place. **Action**: FC/NP to plan immediate action in terms of priority communications to the public regarding access to services. **Action**: NP to bring an update in terms of implementation to the Board on a quarterly basis. **Action**: DW to update the Board on the Estates review at the next meeting.	FC / NP NP DW
10.	**Milton Keynes (MK) Together Health and Care Partnership – MK "Deal"** The paper summarises and sets out different aspects of the Milton Keynes (MK) "deal", namely formalising commitment of partners at place, affirming the four initial strategic priorities for MK and seeks a delegation of remit and resources to help MK to deliver on these priorities.	

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	There was a wide discussion on the paper and the wider system, with the following key points made: - MK has been shortlisted nationally to be one of the integrated discharge front runner programmes. If the bid was successful it would accelerate one of the key priorities which is to avoid unnecessary hospital stays; - MK is not yet ready to take on everything in the paper, and timeframes for maturity were requested; - Once there is a clearer picture of timeframes and what will be delivered at place and what through the ICB, the level of resource needed to support can be determined; - Performance measurement metrics across the system are being worked through, to take into account local dynamics and with a focus on quality; - Will be helpful to work through mutual expectations on some of the high impact areas, such as quality and transformation; - There is matrix working, and it will be important to have transparency; - Must avoid duplicate transformation and ensure that, for each priority, it sits where best, whether at the system or at place. The Board recognises and **endorses** the new place-based partnership structures that have been put in place in Milton Keynes. The Board tasks the ICB Executive Team to work with MK partners to identify what roles and responsibilities can be delegated to the Milton Keynes place-based partnership, in line with the improvement areas identified. **Action**: The MK/ Executive Team to update the Board at the meeting on 30 September, to include timeframes for maturity.	FC / Exec Team / MK Partners MB / FC
11.	**Commissioner Review of Percutaneous Coronary Intervention (PCI)** Percutaneous Coronary Intervention (PCI) is a minimally invasive procedure to open blocked arteries in the heart. It consists of a traditional 'Angioplasty' (using a balloon to stretch open a narrowed or blocked artery) coupled with a stent inserted into the artery. PCI services are needed by some of the most unwell patients and is often time critical. Following a proposal by Milton Keynes University Hospital (MKUH) to develop local PCI services, Felicity Cox, Chief Executive, requested a commissioner review of PCI provision, which was agreed by David Carter and Joe Harrison. PCI is currently available from Bedfordshire Hospitals Trust at both sites, but not in Milton Keynes. The proposal seeks to start delivering PCI to patients in Milton Keynes, and for this to be overseen by Oxford University Hospital (OUH), and for the integration of services at Bedford and Luton & Dunstable Hospitals. The Board **supported** Option 2 as outlined above and within the paper, and the broader recommendations.	

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	Dissent - DC did not support the change, as he considered that integrating the Bedford and Luton & Dunstable Hospitals would reduce resilience rather than increase it; and - LC supported the proposal, but on the proviso that there is no detriment in quality to the population of Bedfordshire. In relation to the financial impact, DC stated that, whilst finance teams have agreed the activity numbers, they have not agreed a transfer of funding reflecting the current situation where Trusts are funded as block amounts with no automatic increase in funding as activity rises and no automatic reduction in funding as activity falls, and in any case released capacity would be used for wider elective recovery requiring the funding to be retained. There was a general discussion around the treatment of stranded costs and savings arising from service changes and reconfigurations, and it was agreed that the System Finance Directors' Group would be asked to develop a set of principles to be agreed. **Action**: After the meeting, RA to circulate a one-page document setting out any potential impact on Bedfordshire. **Action**: Quality Impact Assessment to be done across all three sites to give assurance to Board – AM/SW. To be circulated and action taken through **Chair's Action.**	RA AM/SW/FC/RM
12.	**Strategic Risk Management Integrated Care Board – Board Assurance Framework (BAF)** The paper set out the proposed approach to developing the management of strategic risks for the ICB and ICS for the Board's information and assurance in advance of further discussion at the Board meeting in September. The system BAF will be partially fed by place and partially generated by system-wide risks. It was noted that this report was an introduction and that the process for managing strategic risks will evolve. It was suggested, and agreed, that, as our area has 3 of the 4 fastest growing populations, this should be included as a risk. The cost of living and the impact on the population should also be added to the BAF. It was suggested that if any potential risks come to mind, to advise MW. **Action**: Ola Hill to add population growth, and cost of living, in our geography as a risk **Action**: Any other suggestions for potential risks to be notified to MW. The Board: - **noted** the report and the work underway to further develop system strategic risk management processes and the assurance that the system and organisation are being managed via existing processes; and - **noted** the current risks recorded on the ICB's Board Assurance Framework as presented at the meeting.	Ola Hill All
13.	**People Board Update**	

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	The paper was taken as read and the Chief People Officer (CPO) walked through some of the highlights of the report**.** The Chief Executive has tasked the CPO with looking at how we can work collectively across the workforce and broaden our offer to the workforce as a system. The CPO confirmed that there has so far been a very collaborative approach with Human Resource Directors (HRDs) in the wider system. She highlighted that attrition of 1st year newly qualified nurses is 6.2% compared to 14.5% in the region, which is a reflection of the amount of support that has been given in this area. Care workers are one of the biggest issues, especially as many have moved into another industry during the pandemic and are reluctant to return due to the pay levels. DC suggested this might be something that the ICS could help to change. The Board needs to have the confidence that the People Board is looking underneath the data to focus and solve the most pressing workforce issues. The members **noted** the current work and changes being made to the People Board and key dates: - the appointment of Martha Roberts as substantive Chief People Officer (CPO) who will Chair the Board from September; - New Terms of Reference with revised membership to better engage system transformation leaders; - Development of a new People Plan for September; and - Development of a long term People Strategy alongside the ICS's strategy for December. **Action**: MR to bring revised People Plan and Strategy to the September meeting.	MR
14.	**Quality and Performance Statement** Performance metrics are part of the data we use to understand quality and safety for the patient and what it feels like as a service user. The Board has already talked about not having duplication, working together and the ownership of metrics and all of this will require broader discussion. There is detail on some key areas including Covid-19 cases, elective recovery, emergency care and flow, cancer care and primary care are all included within the report – which are positive and give us an idea of where we are going. The Quality Team has very strong relationships across the system and, they have worked well with the various organisations to focus on the maternity transformation programme and response to Ockendon. Workforce and models of continuity of care challenges are also being addressed together. There was a Central Bedfordshire Council SEND revisit from Ofsted and CQC for which we await the outcome. Luton Council also expect a visit soon. There will be good sharing learning from these inspections.	

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	The team oversaw the closure of Lakeside Hospital, where 29 patients with learning difficulties and mental health issues were resident. Although there was only 1 resident from BLMK, we were host commissioner and had to liaise with 21 other commissioners across the UK to relocate all of these patients. Going forward, we need to think about how we use this data and what we need to give the Board for assurance. We must then use the data and also listen to the voice of the people to determine what we will do going forward. Much work is ongoing in relation to safeguarding, where more triangulation may be needed with partners, local authorities, police and fire services. The Board **noted** the report.	
15.	**Integrated Care Board Finance Plan 2022/23** The paper set out the ICB revenue budget for the year, which was previously approved by the Governing Body of the Clinical Commissioning Group (CCG) and sets out a summary of the BLMK ICS finance plan. The total ICB budget for 2022/23 is proposed as £1.76bn, and revenue budgets for 2022/23 have been built up from the 2021/22 second half year (H2) Operational Plan baseline. However, the plan includes utilisation of non-recurrent mitigations and further work is required to deliver a sustainable financial position for 2023/24 and the medium term. This year saw a move away from the very simplified NHS Covid financial regime, to support the next phase of service restoration, underpinned by system collaboration and collective national responsibility. A balanced financial approach was taken in the development of both the BLMK operational and national plan support for the current year, and a balanced financial plan was submitted to NHS England on 20 June, as agreed by the System Chief Executives and Finance Directors. As the CCG ended on 30 June, two sets of accounts are being prepared this year. Accounts for the first three months have now closed and will be audited at the end of the year, along with a second period accounts, for the remaining 9 months of the year. ICB funding and allocations for this year are annualised based on the second half of last year, and will be adjusted for growth, inflation, efficiency targets and a convergence adjustment towards a fair share funding allocation for all systems in the country. For ICBs as opposed to trusts within the system, we are working on a flat cash basis for running costs (the envelope within which we have to manage). We also have to absorb our own pay increase costs. At the time of planning, we were advised to plan for 2%, which would equate to c. £500k for the ICB. This figure looks like being nearer 5% which would represent a real time reduction in our running costs. It is hoped that there may be some mitigation, but we have to assume for now that we must absorb it all.	

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	Key financial assumptions around the Mental Health Investment Standard Hospital Discharge Fund are contained in the paper. This year we put in place a non-recurrent solution through S256 agreements with local authorities. Plan for the ICB is balanced, predicated on the delivery of £15.5m of efficiency savings. Going forward, we will also have to address our underlying financial position, deficit of £15m. The system has delivered a balanced financial plan. At draft stage, the deficit of c £40m was agreed by Chief Executives and Finance Directors, which was largely driven by the inflationary pressures above planning assumptions published last Dec and the ongoing prevalence of Covid. The plan submitted showed a significant underspend for this year, but that includes £17m of non-recurrent measures to balance this year. System Directors are confident that they can achieve that but we need to find a more sustainable solution for the future. Overall efficiencies across NHS organisations this current year total £56m and we are broadly on track at the end of Q1 to achieve that, with the risks being primarily inflationary, pay settlements, delivery of efficiency plans as a system and delivery of elective recovery targets. The Board: - **Noted** the key assumptions set out in this paper; - **Noted** the overall ICS Financial Plan submission; - **Approved** the nine-month indicative Integrated Care Board budget as set out in this paper; and - **Delegated authority** to the Finance & Investment Committee to review the impact on Integrated Care Board budgets following the closedown of the Clinical Commissioning Group.	
16.	**Committee Reports** Cllr Tracey Stock, Chair of the Health & Care Partnership reported that two shadow meetings had been held in March and in May, at which the values and strategy had been the focus. The first meeting within the new ICB framework had taken place on 4 July with a focus again on strategy. The members **noted** the minutes from the meeting of the Health & Care Partnership on 4 July, and the verbal update given by the Chair, Cllr Tracey Stock.	
17.	**Questions from the Public** One question had been received from a member of the public, who was in attendance today, which related to Functional Neurological Disorder (FND). The Chief Medical Director outlined the question and gave a verbal response at the meeting. She offered to discuss further with the individual offline if it would be helpful. The full question and prepared response is attached to these minutes. No further questions have been received from the public.	

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18.	**Committee Membership** The Head of Governance presented a paper on Committee membership and highlighted changes to the Terms of Reference and Committee membership, which would in turn necessitate changes to the Governance Handbook: The members: - **approved** the amendments to the Committee Terms of Reference set out in Appendix A and noted that the Governance Handbook will now be updated to reflect the changes; - **approved** the latest appointments to Committee membership sine 1 July 2022 set out in Appendix B and agreed to finalise outstanding vacancies by 31 August 2022; and - **noted** that a revised Terms of Reference for the Working with People and Communities Committee will be brought to the September meeting.	
19.	**Integrated Care Board Forward Planner** The items provisionally scheduled for the next meeting were noted: - Working with People & Communities Strategy; - Winter Plan; - Audit Committee appointment of ICB auditors; - Bedfordshire Care Alliance progress/forward look; - Head and neck cancer services; - Workforce Race Equality Standard (WRES); and - System Assurance: East Kent Maternity Report - inclusion depending on publication date. In addition, the Chair advised that the ICB is responsible for signing off the CCG's annual report and accounts for Q1 of 22/23 and these will be coming to board via appropriate ICB committees on 30th September. The Board is required to hold an AGM to receive the 21/22 CCG Annual report and Accounts in September (date 27/9/22), this will be a short meeting via MST to deliver the statutory minimum requirement. **Action**: KA to add 2 items to the Annual Cycle of Business.	KA
20.	**Communications from the Meeting to all Partner Organisations** This item was not covered due to insufficient time.	
21.	**Committee Effectiveness** This item was not covered due to insufficient time.	
22.	**Any Other Business** No items had been received.	

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23.	**Date and Time of Next Meeting:** The next meeting will be held on Friday 30 September 2022 from 10 – 1.30 at Sherwood Place, Sherwood Drive, Milton Keynes, MK3 6RT. *The meeting will be followed by a development session.* *Post meeting note: the next meeting will now be held in the Milton Keynes Council Chamber.* The meeting ended at 12.54. Attached: Question & Answer from member of the public on FND	

Approval of Minutes:		
Name	Role	Date
Rima Makarem	Chair	18/8/2022

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APPENDIX

Question from Member of the Public on Functional Neurological Disorder (FND)

QUESTION

In light of the response from MKUH to the provision of an integrated pathway for FND and in particular:

"The further development of integrated care (with the advent of the BLMK Integrated Care Board) offers a new opportunity for all system partners to re-engage with the FND agenda, as service development is likely to be attractive to care providers as well as patients. MKUH has raised the issue at the Milton Keynes Joint Leadership Team and will look to identify a partner organisation in Milton Keynes to take forward the discussion at BLMK on our behalf."

Can the ICS partnership board confirm:

A) why an integrated pathway for FND has not been developed thus far
B) when will there be a proposal to create such a pathway before the board
C) what is the timescale to make such a service available to patients
D) what definition of FND does the Board use and does this include dissociative seizures (also known as PNES or functional seizures)

ANSWER

Functional Neurological Disorder (FND) is a brain disorder that can encompass a diverse range of neurological symptoms including limb weakness, paralysis, seizures, walking difficulties, spasms, twitching, sensory issues and more. Symptoms can be severe, disabling and life changing.
The basic wiring of the nervous system is intact, but there is a problem with how the brain/nervous system is "functioning", and how the brain fails to send and/or receive signals (messages) correctly. This impacts on how the body responds to different tasks such as movement control and attention.

Due to the diversity of symptoms that may present with a Functional Neurological Disorder, and the varied potential causes/triggers that can differ from person to person, treatment plans should be tailored to suit the person's individual need. There is not a 'one fix will fix all' option, which can cause frustration for both the person with the diagnosis and clinicians, so it may take time to develop the correct treatment plan.

The majority of patients with FND have their needs met by mainstream services, such as Physiotherapy and Occupational Therapy. These are widely accessible and can be referred by the patients lead clinician. A small number of patients with FND have complex needs which fall outside the remit of routine commissioned services. Over the years, these needs have been met through collaboration between Acute and Community providers, and commissioners to create an individualised package of care. These packages of care have varied, with some having care at home and some needing in-patient rehabilitation with a specialist provider. In recent months this process has been strengthened with the formation of a Multi-disciplinary Team meeting – where all the different clinicians involved in the patients care work together to help coordinate care. At present, there is no defined integrated pathway for FND due to the low number of patients and the lack of a nationally defined treatment models covering all areas of need - which is why in Milton Keynes we have taken a more individualised approach. However, it is hoped the MDT approach recently introduced will bring more structure to the needs assessment and generate intelligence about where our health care commissioning gaps may be.

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There are many definitions of FND all with a slight variation. One example is below. The ICB acknowledges this and has therefore not agreed to a single definition of FND, instead focusing on the diagnosis, individuals needs and how we can best manage those needs. This avoids a scenario where a patient cannot access a service purely because of the definition wording. The FND concept is however widely understood.

This definition from FND website:
"Functional Neurological Disorder provides an umbrella term for a variety of symptoms of apparent neurological origin but which current models struggle to explain psychologically or organically. Presentation may be similar to a wide range of other neurological conditions. FND/CD can be as debilitating as Parkinson's disease and MS and have many similar symptoms. The most common misconception is that patients are in control of some or all of their symptoms. The patient does not consciously produce functional symptoms. https://fndhope.org/fnd-guide/symptoms/#)

The ICB has a number of priorities informed by population health data as well as national guidance. We have a current focus on health inequalities which create unfair and avoidable differences in health across the population, and between different groups within society. We know these inequalities are related to various factors that may include socio-economic issues, ethnicity, age, culture and demographics we will be looking to reduce these variations in 5 main areas: early cancer diagnosis, diagnosing Hypertension in order to prevent people having strokes later in life, increased uptake in vaccinations particularly for those with respiratory disease, maternity care, continuity of care for those in black and minority ethnic (BAME) groups and health checks for those with severe mental illness (SMI).

End

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NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
4. Review of Action Tracker

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☐	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☐	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☐	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☐	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☐	Ways of working ☐	Estates ☐
Communications ☐	Finance ☐	Operational and Clinical Excellence ☐	Governance and Compliance ☒
Other ☐ (please advise):			

What are the members being asked to do?		
Approve ☒	Note ☐	Discuss ☐

Report Author	Secretariat
Date to which the information this report is based on was accurate	21-09-2022
Senior Responsible Owner	Chair of the Committee

Executive summary
The purpose of this paper is to review the Action Tracker by updating actions with progress, and to agree closure of proposed completed actions.
What are the available options?
To close, update or amend actions listed on the Action Tracker.
Recommendation/s
The members are asked to **approve** the Action Tracker.
Key Risks and Issues
There are none identified.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

There are none identified.
Are there any financial implications or other resourcing implications?
There are none identified.
How will / does this work help to address the Green Plan Commitments? Click to view Green Plan
This is not applicable in this circumstance.
How will / does this work help to address inequalities?
This is not applicable in this circumstance.
The following individuals were consulted and involved in the development of this report:
The Committee Chair.
Next steps:
The Secretariat will finalise the Action Tracker, e.g., make required amendments and save as approved.
Appendices
Appendix A – Draft Action Tracker

Meeting of the *Board of the Integrated Care Board* - Action Tracker

APPENDIX A

Key

Escalated	**Escalated** - items flagged RED for 3 subsequent meetings - BLACK
Outstanding	**Outstanding** - no actions made to progress OR actions made but not on track to deliver
In Progress	**In Progress.** Outstanding - actions made to progress & on track to deliver due date -
Not Yet Due	Not Yet Due
COMPLETE: Propose closure at next meeting	**COMPLETE** - GREEN
CLOSED (dd/mm/yyyy)	CLOSED

Items to be moved to "closed actions" once closed

Action No.	Meeting Date	Item Title	Action	Responsible Manager (Enter full name)	Past deadlines (Since Revised)	Current Deadline	Current Position	RAG (Add date action is agreed closed)
5	29/07/2022	Register of Interests	To obtain date of cessation of O. Kufeji interest relating to Clinical Commissioning Group, and then to update register re this, and D Carter not being employed at Bedfordshire Hospitals Trust in a voluntary capcity	Kim Atkin		30/09/2022	Obtained date of cessation of O.Kufeji interest at Clinical Commisioning Group and updated register accordingly. Discovered avid Carter's Conflicts of Interest form had been incorrectly completed, but have updated Bedfordshire Hospitals Trust employment as a financial interest.	**COMPLETE: Propose closure at next meeting 30/09/2022**
6	29/07/2022	100 day Plan - public	Public-facing version of 100 Day Plan to be circulated widely and made available online	Jane Meggitt		30/09/2022	This has been woven into the 100 day plan report. Comms have uploaded a page, which included a blurb about what we're doing and a link in the document to the pledge document. https://blmkhealthandcarepartnership.org/our-priorities/our-pledge-to-you/	**COMPLETE: Propose closure at next meeting 30/09/2022**
7	29/07/2022	Peer Accountability	To take forward peer accountability across the system at System Oversight Assurance Group and CEO Groups	Felicity Cox		Mar-23	17/8 Individual discussions being held with each CEO and then discussion at CEO Forum in October. Approach will be tested and refined throughout the year.	**Not Yet Due**
8	29/07/2022	Resident's Story	To take forward for next meeting and propose resident's story / item to be tabled later in agenda	Maria Wogan / Kim Atkin		30/09/2022	Noted to be later in agenda on ACOB. For September this will be part of the Children & Young People deep dive during development session	**COMPLETE: Propose closure at next meeting 30/09/2022**
9	29/07/2022	ICB Strategy	To prepopulate the strategy from existing work and to consider adding the word "happier" to our mission statement	Richard Alsop		30/09/2022	14/9 Strategy development is progressing well. We have been working with the Health and Care Partnership to identify key themes to include in the strategy. A core element of our this work to date has been a review of existing strategies and plans and insight from people and communities which will sit at the core of our final system strategy. We will be engaging with relevant stakeholder boards over in October and November to test the key themes emerging from this work. Having reviewed our mission 'happiness' is already part of our vision insofar as 'healthier' includes emotional wellbeing. The advantage of emotional wellbeing as our guide is that there are tools to measure this.	**COMPLETE: Propose closure at next meeting 30/09/2022**
10	29/07/2022	Children & Young People	To bring the outcome from the Children & Young People deep dive to the Integrated Care Board in September	Tracey Stock / Dr Rima Makarem		30/09/2022	To be covered in 30/9 development session	**COMPLETE: Propose closure at next meeting 30/09/2022**
11	29/07/2022	Place Strategies	To reflect Place strategies in Intgrated Care System Strategy review	Richard Alsop		30/09/2022	13/9 It is our intention to reflect place strategies in the Integrated Care System strategy document and indeed deliver much of the strategy at place	**COMPLETE: Propose closure at next meeting 30/09/2022**

Action No.	Meeting Date	Item Title	Action	Responsible Manager (Enter full name)	Past deadlines (Since Revised)	Current Deadline	Current Position	RAG (Add date action is agreed closed)
12	29/07/2022	Local Strategies	All partners to contact RAlsop in relation to existing local strategies and plans beyond Health and Wellbeing Board strategies	All partners		30/09/2022	17/8 emailed partners as a reminder , to close as request issued	**COMPLETE: Propose closure at next meeting 30/09/2022**
13	29/07/2022	Development of Health & Care Partnership Strategy and Joint Forward Plan	All partners to identify relevant Boards to discuss the development of the Health & Care Partnership strategy and set the foundation for the system Joint Forward plan by 8 August 2022	All partners		30/09/2022	17/8 emailed partners as a reminder, to close as request issued	**COMPLETE: Propose closure at next meeting 30/09/2022**
14	29/07/2022	Strategy T&F Group	To report back on Task & Finish Group at September meeting	Richard Alsop		30/09/2022	To be covered within Chief Executive's update on 30/9.	**COMPLETE: Propose closure at next meeting 30/09/2022**
15	29/07/2022	Public comms - access	Plan immediate action in terms of priority comms to the public regarding access to services, following Fuller Stocktake	Nicky Poulain / Maria Wogan		30/09/2022	A plain English leaflet is being developed with primary care which will show all the access points for primary care for local people. This will be shared with all partners across the system and local authority colleagues are being asked to support this through their channels, where messages are delivered at place. An access page will also be available on our website – which explains how people can access and the work we are doing to boost capacity and address the telephone issues people are facing. This is scheduled for distribution in October.	**COMPLETE: Propose closure at next meeting 30/09/2022**
16	29/07/2022	Fuller Stocktake	To bring an update in terms of implementation following Fuller Stocktake, to the Board on a quarterly basis	Nicky Poulain		25/11/2022	On Annual Cycle of Business.	**Not Yet Due**
17	29/07/2022	MK Deal	ICB Exec Team to work with partners to identify what roles and responsibilities can be delegated to the MK place based partnership, in line with the improvement areas identified	Felicity Cox / Integrated Care Board Exec Team / MK Partners		30/09/2022	19/8 Confirmed meetings have been set up and work is underway.	**COMPLETE: Propose closure at next meeting 30/09/2022**
18	29/07/2022	MK Deal	To update the Board at September meeting on MK Deal, to include timeframes for maturity	Michael Bracey Felicity Cox		30/09/2022	On agenda for 30/9 meeting.	**COMPLETE: Propose closure at next meeting 30/09/2022**
19	29/07/2022	Review of PCI	Circulate a one-page document setting out any potential impact on Bedfordshire	Richard Alsop		29/07/2022	17/8 - Email sent from CEO with one pager and Quality Impact Assessment - requesting feedback and reaffirming agreement for Chair's action to approve.	**COMPLETE: Propose closure at next meeting 30/09/2022**
20	29/07/2022	Review of PCI	Quality Impact Assessment to be done across all three sites to give assurance to Board. To be circulated and action taken through Chair's Action.	Anne Murray / Dr Sarah Whiteman Felicity Cox / Dr Rima Makarem		30/09/2022	17/8 - Email sent from FC with one pager and Quality Impact Assessment - requesting feedback and reaffirming agreement for Chair's action to approve.	**COMPLETE: Propose closure at next meeting 30/09/2022**
21	29/07/2022	Business Assurance Framework	To add the increasing population in our geography and cost of living as a risk	Ola Hill		30/09/2022	13/9 - Cost of Living has been added to the ICB Business Assurance Framework (ref BAF 9).	**COMPLETE: Propose closure at next meeting 30/09/2022**
22	29/07/2022	Business Assurance Framework	Any suggestions of potential system risks to be notified	All partners		30/09/2022	17/8 emailed partners as a reminder. 13/9 Head of Risk confirmed that no further suggestions were received, advised to close.	**COMPLETE: Propose closure at next meeting 30/09/2022**

Action No.	Meeting Date	Item Title	Action	Responsible Manager (Enter full name)	Past deadlines (Since Revised)	Current Deadline	Current Position	RAG (Add date action is agreed closed)
23	29/07/2022	People Plan and Strategy	To bring revised People Plan & Strategy to the September meeting.	Martha Roberts		30/09/2022	On agenda for 30/9.	**COMPLETE: Propose closure at next meeting 30/09/2022**
24	29/07/2022	Annual Cycle of Business	To add two items regarding sign of of annual report and accounts and AGM to the Annual Cycle of Business	Kim Atkin		30/09/2022	Sign off on Annual Cycle of Business and AGM in planning.	**COMPLETE: Propose closure at next meeting 30/09/2022**
25	29/07/2022	Estates	Following Fuller Stocktake discussion, to bring upate on estates utilisation to next Board	Dean Westcott / Nikki Barnes		30/09/2022	Confirmed Head of Estates to present on 30/9	**COMPLETE: Propose closure at next meeting 30/09/2022**

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
6. Chief Executive Officer's Report

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☒	Ways of working ☐	Estates ☐
Communications ☐	Finance ☒	Operational and Clinical Excellence ☐	Governance and Compliance ☒
Other ☐ (please advise):			

What are the members being asked to do?		
Approve ☐	Note ☒	Discuss ☐

Report Author [name and role]	Felicity Cox Chief Executive
Date to which the information this report is based on was accurate	20 September 2022
Senior Responsible Owner	Felicity Cox Chief Executive

Executive summary

This report provides a summary of corporate activities since the last Board meeting on 30th July 2022.

In the past three months, a significant amount of work has been delivered in a range of areas – from the delivery of the 100-day plan to development work in primary care around the Fuller Review and in terms of developing more sustainable approaches to primary care provision, preparation for the delegation to the ICB of commissioning of community pharmacy, optometry and dental services from NHS England, proposals to deliver efficiencies in 2022/23 and the development of the ICB's Board Assurance Framework.

This report provides an update on appointments to the Executive team and provides assurance to the Board on the delivery of Operation London Bridge, which saw the system come together to maintain vital services following the death of HM The Queen earlier this month.

What are the available options?

Not applicable

Recommendation/s

1) The Board is asked to note the report.

Key Risks and Issues

This paper provides an update on the development of the ICB's Board Assurance Framework which contains strategic system-wide risks.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐

BAF 19

Are there any financial implications or other resourcing implications?

None

How will / does this work help to address the Green Plan Commitments?
Click to view Green Plan

Not applicable

How will / does this work help to address inequalities?

Tackling health inequalities runs through all the programmes outlined in this report.

The following individuals were consulted and involved in the development of this report:

Maria Wogan, Chief System Assurance Corporate Services
Lynn Dalton, Associate Director Primary Care Development
Abimbola Hill, Deputy Head Organisational Resilience
Paul Burridge, Head of Programme Management Office
Rebecca Green, Deputy Programme Director ICS Establishment

Jane Meggitt, Director Communications and Engagement
Next steps:
As described in the report
Appendices
Appendix A – 100-day plan progress report Appendix B – ICB Guidance

1. **Collecting Case Studies on how we are working together to deliver improved health and care 'Moments that Matter'**

   The ICB team is working with partners to develop a bank of case studies to show how the system is improving outcomes for local people. The 'Moments that Matter' campaign will showcase the work of partners and will be used on in printed media, social media, website and published in the monthly ICS stakeholder newsletter.

   The following case studies are examples of how we can use stories to show the benefits of integrated working to residents.

   Jane is from Houghton Regis and has learning disabilities. She has benefitted from working with Victoria Harding and the social prescribing team at Titan Primary Care Network in Central Bedfordshire.

   Jane said:
   "Before (I met Vicky) I didn't know who to call or speak to so I would call the GP or 999 if I was worried. Because Vicky came to see me, she was able to really see what my life was like and offered to help me. She worked with the council for repairs to my flat, she looked at my benefits and helped me to claim so I have been able to make more improvements to my flat. I'm exercising now and going out socially which I didn't do before, I have even made some new friends. Now I know who to call if I'm worried or if I don't understand something. Working with this service via my GP has made my life easier, better and happier, I like me now. Everyone should have a Vicky".

   The following is from a school who has benefitted from a neurodiversity support pack which was co-produced by Cambridge Community Services and partners from across health and social care, and local families to provide support for young people and their families who have received a neurodiverse diagnosis.

   A local school representative said:
   "This is fantastic, thank you very much. It is very important to see the positive approach and detailed information. I have shared with parents and staff, and have had many great responses from parents, as well as staff, who have children with Autistic Spectrum Disorder (ASD). So please pass our thanks on."

   Other case studies in development include:

   - An autism key worker case study showcasing 'B', a young person who benefitted from personal health budgets to pay for driving lessons and boxing lessons to reduce stress and anxiety, help her with healthy eating and social interaction.
   - 'Olivia low calories diet' programme, which showcases three local people who have lost weight to prevent them from becoming diabetic and to improve their confidence and overall health and wellbeing.
   - Diabetes prevention programmes, which have helped local people to reverse Type 2 diabetes and get them off medication to live a healthier lifestyle.

- Child epilepsy pilot in Luton which is centred around the 'Patients know best' approach. It provides a digital space for professionals and families to connect so that they feel supported between meetings. The space allows for the sharing of videos and information about seizures so that patterns can be identified.
- Lung Health Check case studies from Luton where local people have attended Lung Health check screening events in the town and cancer has been detected at an early and treatable stage.

Partners are requested to share case studies with the communications and engagement team blmkicb.communications@nhs.net

2. Death of Her Majesty Queen Elizabeth II

At the beginning of September, partners from the Bedfordshire and Thames Valley Local Resilience Forums (LRFs) delivered Operation London Bridge after the sad death of Her Late Majesty Queen Elizabeth II. The ICB was responsible for co-ordinating the health response across BLMK. Plans for the death of the monarch have long been in place and were implemented well with sensitivity. Health and care partners worked well together and with wider system partners to ensure that vital services were delivered during the Bank Holiday period. I would like to thank colleagues from across the system for their contribution to this work.

3. ICB 100-day plan – progress report

In July, a plan was published to outline the ICB's deliverables in its first 100 days, alongside a document which described how the system was working collaboratively to deliver improved health and care for residents. Now approaching day 90, the ICB is on track to deliver that plan by day 100 or shortly after.

Key areas of work delivered so far include:

- The ICB has co-located with Central Bedfordshire Council at Priory House and Bedford Borough Council at Borough Hall
- A festival of learning to help staff to build their skills to support the new organisation has run over the summer months and will continue into the autumn.
- The first-place based reports have been produced and circulated to colleagues, the process continues to review and refine the reports based on place and sub system feedback.
- Health & care strategic clinical leaders have been appointed. A list has been included as Appendix B
- All ICB Committees have met and agreed their workplans
- Engagement with communities has been ongoing, as part of the Denny Review (led by Healthwatch and the VCSE) to understand what barriers prevent people from seldom heard communities from accessing health and care services.

Where slippage has occurred, it is because key meetings have been moved into October or later and these deliverables are highlighted as Amber in the attached progress report. There are no areas on the 100 Day Plan risk reviewed as Red.

4. Transition of NHS England (NHSE) delegated commissioning functions for Pharmacy, Optometry and Dental services to the Integrated Care Board from April 2023.

Section 65Z5 of the Health and Social Care Act (2022) allows for the delegation of commissioning functions from NHSE to Integrated Care Boards (ICB). Functions are being transitioned on a phased approach and this began on 1 July this year when primary care medical services (GP) contracts including Quality & Outcome Framework, Management of Directed Enhanced Services (including Primary Care Networks) and contracting were delegated from NHS England to the Integrated Care Board to build on the areas previously held by the CCG from 2017/18 for its 95 GP contracts. GP contractors complaints function, freedom of information requests and communication cascade were due to transition to the ICB in 2022, this has been delayed until 2023 and will transfer for all contractor groups but subject to a decision by NHS England National Moderation Panel (NMP) on the proposed staffing resource to support these functions being made in October 2022.

In April 2023, the next phase of the transition will begin with the delegation of responsibility for primary care community Pharmacy, Optometry and Dental (POD) contracts to the ICB.

The primary care team is working with regional and national colleagues to prepare for the transition of commissioning responsibility for 163 pharmacy, 86 optometry and 148 dental (2 acute and 3 community) contracts in our area.

On 9 September, we submitted a draft Pre-Delegation Assessment Framework (PDAF) application form and Safe Delegation Checklist (SDC) to the regional team as the first step in this transition.

The documents are currently being reviewed and the regional team will submit the PDAF and a regional staffing model for the transition of subject matter experts (to be transferred to the ICB to support delegation) to the National Moderation Panel (NMP) in early October.

The NMP will make its recommendations to NHSE Board in early December 2022, and we expect to receive approval for these functions to be delegated to us by mid-December.

We are currently working to provide assurance to the regional team that the ICB is ready to take on the delegated commissioning for pharmacy, optometry, and dentistry, while also receiving assurances that there will be a wide range of resources available to support these functions, including finance, staffing, nursing and safety including complaints.

The ICB will continue to work with NHSE's regional team using the safe delegation checklist to ensure the assurances are in place before March 2023.

The Primary Care Commissioning and Assurance Committee will provide oversight and assurance of the process on behalf of the Board. A final decision to accept the new delegated authority will be made by the ICB Board in February 2023.

5. Procurement of Alternative Provider of Medical Services (APMS) GP contracts

Supported by specialist procurement advisors, Attain, BLMK ICB has completed a 'multiple lot' procurement exercise to find new providers of services at Arlesey Medical Centre and Shortstown Surgery located in Central Bedfordshire.

Both have list sizes of under 5,000 patients and are currently being provided under Alternative Provider Medical Services (APMS) contracts which are time limited (unlike to the more common General Medical Services (GMS) contracts which operate in perpetuity). Both contracts come to an end on 31st October 2022.

In line with our procurement strategy not to reprocure practices of under approximately 10,000 list size as stand-alone surgeries, the two practices were offered as 'branches with patient lists' to providers holding a GMS contract through an open transparent competitive tender process. This was considered the best option to ensure the long-term robust and resilient delivery of general practice services in each village.

Four practices submitted bids and following a robust evaluation and moderation of the bids the contracts were awarded as follows:

- Larksfield Partnership, based in Stotfold, the neighbouring village to Arlesey, has been appointed to take on the Arlesey Medical Centre building as a branch surgery and all registered patients will be transferred to Larksfield, subject to patient choice. It is anticipated that disruption for patients will be minimal as MK GP+ who currently provide services at Arlesey are now also supporting Larksfield Surgery and so will continue to be involved in the running of Arlesey as a branch.
- Wootton Vale Healthy Living Centre has been appointed to take on the Shortstown Surgery building as a branch surgery and all registered patients will be transferred to Wootton Vale. Patients may of course choose to register elsewhere but given that Wootton Vale are already providing services at Shortstown it is anticipated that the overwhelming majority will wish to continue receiving services there.

Work to mobilise both contracts is now underway. This was an opportunity for local GMS contractors to bid for the practices and whilst it is a challenging time in primary care it has demonstrated that there are practices in the ICB that have an appetite to extend their business and merge to ensure contractual perpetuity and sustainability. Communications with local people and stakeholders been undertaken to ensure people have been made aware of how the changes will affect them and to ensure they have the necessary support in place for those with concerns.

6. The BLMK plan for 'Next steps for Integrating Primary Care: Fuller Stocktake Report'

Earlier this year, Dr Claire Fuller, Chief Executive Officer Surrey Heartlands ICS and a GP published a report which provided a clear framework for the further development and integration of Primary Care. The Board received a presentation on this report at its last meeting. The recommendations from the Fuller Stocktake fall into 4 key recommendations.

- Develop Integrated neighbourhood 'teams of teams' from Primary Care Networks (PCNs) that will be rooted in a sense of shared ownership for improving the health and wellbeing of the population. The teams should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities
- Ensure streamlined access to urgent, same-day care and advice from an expanded multi-disciplinary team, using data and digital technology to enable patients to quickly find the right support to meet their needs.
- Ensure those who would most benefit from continuity of care in general practice (such as those with long term conditions) can access more proactive, personalised support from a named clinician working as part of a team of professionals.
- Take a more active role in prevention and create healthy communities and reduce incidence of ill health by working with communities, making more effective use of data, and developing closer working relationships with local authorities and the voluntary sector.

The ICB will adopt and implement these recommendations and a system wide Fuller Framework Programme Plan is now in development.

The BLMK plan will illustrate the delivery of these four recommendations at place and neighbourhood; capturing work that is already underway, demonstrating the connectivity and contribution this will make; and describing new interventions and transformation required. The plan will be co-produced with system partners, stakeholders and place boards and training and development will be arranged for place based primary care team and Primary Care Networks in 2023/24.

At the heart of the new vision for integrating primary care is bringing together previously siloed teams and multi-agency professionals to do things differently to improve patient care for whole populations. Thriving integrated primary care systems need to be built as locally as possible, drawing on the insights, resourcefulness and innovations of residents, patients and their carers, local communities, local government, all NHS teams, VCSE providers and wider system partners.

Neighbourhoods of 30-50,000, where teams from across the PCN, wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.

There is already work taking place that is being built on in developing the plan for example the Leighton Buzzard Working Together project; the new models of care being designed for Grove View (Dunstable Hub); the focused collaborative programme providing integrated support to the residents of the Lakes Estate in Bletchley; and the proactive frailty models developed in Luton.

Access to primary medical services (GP practices) remains a priority across BLMK and the Fuller recommendation to streamline access across practices to manage demand more effectively for urgent same-day primary care seeks to provide more timely access for our population.

7. Developing the Integrated Care Partnership Strategy

Work to develop the Integrated Care Partnership strategy is underway and the draft strategy will be presented to the Health and Care Partnership in December for approval.

The strategy builds on existing strategies that have been developed by partners, both at system and place and includes insights from residents about what they want from their health and care services.

This will be the first iteration of the strategy, which will evolve as the system matures.

On 21 September, an event will be held for partners which will focus on children and young people's health and care. The event will establish the factors which will have a significant impact on the future health and wellbeing of children and young people in Bedfordshire, Luton and Milton Keynes and agree an approach to working together to improve these and set out the focus for the system, including identifying target population groups for this work.

Outputs from this meeting will be shared with the Integrated Care Board at the development session after the Board meeting to inform the development of the Joint Forward Plan which the ICB is responsible for and which is due to be signed off by the ICB in March 2023.

8. Transformation and Efficiencies programme 2022/23

Based on the June Efficiencies plan submission for the ICB, Bedfordshire Hospitals Foundation Trust (BHFT) and Milton Keynes University Hospital (MKUH), our plan is to deliver a combined £55.6m Efficiencies programme in 2022/23 (ICB £15.4m, BHFT £28.2m, MKUH £12m).

Based on Month 5 ICB and Bedfordshire Hospitals Foundation Trust and Milton Keynes University Hospital Provider Financial Returns.

- ICB is very slightly below plan YTD (£17k variance) and forecasting break even by year end.
- MKUH is breakeven YTD (£2.6m delivered) and forecasting breakeven by year end.
- BHFT is below plan YTD (£6.9m delivered against a £11.7m plan) but is forecasting breakeven by year end.

Discussions on the current efficiencies position and what mitigations are in place given the shortfall YTD, will take place at the Transformation & Efficiencies System Partners meeting on 27 September 2022.

9. Month 5 Position

	YTD Plan £'000	YTD Actual £'000	Variance £'000	Variance %	Annual Plan £'000	Forecast Outturn £'000	Variance £'000	Variance %
ICB	5,925	5,908	(17)	0%	15,441	15,441	-	0%
BHFT	11,732	6,907	(4,825)	-41%	28,151	28,151	-	0%
MKUH	2,591	2,591	-	0%	12,049	12,049	-	0%
Total	20,248	15,406	(4,842)	-41%	55,641	55,641	-	0%

10. Transformation programme 2022/23 Q3 & Q4 and 2023/24

At the last meeting of the Board in it was agreed that BLMK should accelerate and widen existing Transformation plans through programme boards, sub-systems (Bedfordshire and MK) and place; to support the identification of recurrent efficiencies in Q3/Q4 2022/23 and 2023/24.

Areas of transformation and efficiency are being developed through collaboratives/partnerships. Focused areas include workforce, estates, procurements, medicines optimisation and the ICB budget

line review. Progress on delivery and development of a pipeline will be monitored as part of the Transformation and Efficiencies System Partners Group.

Linked to this work, the ICB's Programme Management Office is currently undertaking a stocktake of known change activity across the system. This is intended to be a step towards supporting the setting of system priorities for transformation and to providing regular reports to the Board on progress against the achievement of our strategic priorities.

Part of the discussions at the Transformation and Efficiencies System Partners Group on 27 September will be how the BLMK system can meet the ask of the Medium-Term Financial Plan (Oct-22) and the wider discussion on how the system can balance itself and return to pre-covid levels of spend (or close to it). An update from this meeting will be provided at the Board meeting.

11. Developing System Risk Management

Work is underway to develop a strategic risk management approach, which is intrinsically linked to the development of the system's integrated care strategy and joint forward plan. Working with system partners, the following has been identified as key strategic risks on the ICB Board Assurance Framework (BAF) these include:

Ref	Risk Title	Risk Description	Current Risk Rating
BAF 1	Recovery of Services	There is a risk that the NHS is unable to recover elective and cancer services and waiting times to pre-pandemic levels due to Covid related pressures, workforce constraints or demand led pressures. This may lead to poorer patient outcomes and reputation damage.	16
BAF 2	Developing suitable workforce	If system organisations within BLMK ICS are unable to recruit, retain, train and develop a suitable workforce then staff experience, resident outcomes and the delivery of services within the ICS, ICB People Responsibilities and the System People Plan are threatened.	20
BAF 3	System Pressure & Resilience	As a result of continued pressure on services from various factors (staff sickness, increased activity etc) there is compromised resilience in the health and social care system which threatens delivery of services across BLMK. This may lead to poorer patient outcomes and reputational damage.	20
BAF 4	Widening inequalities	There is a risk that inequalities in the system widen due to a range of factors leading to compromise to population health and increases in system pressure in the most deprived areas.	16
BAF 5	System Transformation	There is a risk that because of significant operational pressures, there will be decreased capacity to focus on strategic transformational change to deliver improved outcomes for our population.	12
BAF 6	Financial Sustainability and Underlying Financial Health	As a result of increased inflation, significant operational pressures, patient backlogs and the enduring financial implications of the Covid pandemic - there is a risk to the underlying financial sustainability of BLMK that could result in failure to deliver statutory financial duties.	15
BAF 7	Climate Change	Due to climate change, there is a risk of increased pressure on health and care services and deteriorating population health outcomes.	16
BAF 8	Population Growth	As a result of fast rate of population growth in BLMK, there is a risk that our infrastructure will not keep pace with the needs of our population, resulting in poor health and wellbeing for residents.	16
BAF 9	Rising Cost of Living	As a result of rising cost of living there is a risk that residents will not be able meet their basic needs resulting in deteriorating physical and mental health resulting in pressure on all public services	12

Work continues to refine these risks and the processes that will support escalation, with support from system partners, Chief Executive Officers and Trust risk leads.

In November, a Board Development Session will be held to develop the approach to risk for the system and for the benefit of our population, and at the next Board meeting in November the Board will review the full Board Assurance Framework (BAF) for review.

12. Appointments to the ICB executive director team

The process to appoint the ICB's executive director team has now concluded. The new team comprises:

- Chief Executive – Felicity Cox
- Chief Finance Officer – Dean Westcott
- Chief Medical Director – Dr Sarah Whiteman
- Chief Nursing Director – Sarah Stanley
- Chief Primary Care Officer – Nicky Poulain
- Chief Transformation Officer – Anne Brierley (from 30 September 2022)
- Chief of System Assurance and Corporate Services – Maria Wogan
- Chief People Officer – Martha Roberts

We have appointed a Chief of Staff who will be taking on the Accountable Emergency Officer duties in due course, and interim arrangements we will be put in place by the end of September.

The following clinical appointments have also been made:

Clinical Lead Role	Name	Role
Strategic Clinical Leads	Chirag Bakhai	Long Term Conditions (Respiratory, CVD and Diabetes)
Strategic Clinical Leads	Roshan Jayalath	Mental Health and Learning Disabilities
Strategic Clinical Leads	Shankari Mahathmakanthi	Children and Young People (focus on Mental Health)
Strategic Clinical Leads	Monjour Ahmed	Primary Care Access
Strategic Clinical Leads	Nina Pearson	Workforce and Innovation Hub

13. Key events August and September

The Chief Executive has attended the following events on behalf of the ICB:

31 August	Sue Ryder St John's Hospice – service visit
22 September	Healthwatch Milton Keynes AGM

Key events coming up include:

- BLMK ICS Inequalities Event
- Pharmacy Vision in England Advisory Group
- NHS National Leadership Event

14. Recently published ICB guidance

On 14 September, NHS England published updated guidance for Integrated Care Systems. Full guidance is provided in Appendix B, but key guidance for the Board to note includes:

- **Palliative and End of Life Care Statutory guidance for ICBs** (NHSE)
  Palliative & End of Life Care: Statutory Guidance for ICBs
- **Better Care Fund** (NHSE)
  NHS England » Better Care Fund planning requirements 2022-23
- **Improving cancer outcomes** (FutureNHS)
  Improving cancer outcomes-guidance on how ICBs and Cancer Alliances will work together May 2022 - ICS Guidance - Integrated Care (future.nhs.uk)
  ICB Losses and Special Payments Guidance -
  ICB Losses and Special Payment Guidance Final Approved 30 May 2022 - ICS Guidance - Integrated Care (future.nhs.uk)
- **Health Overview Scrutiny Committees Principles**
  https://www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles

100 Day Plan Progress Tracker - progress at 90 days

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

RAG Definitions	BLUE: COMPLETE	GREEN: ON TRACK	AMBER: TIMELINE DELAYED	RED: UNABLE TO DELIVER
	Complete	The Commitment or Initiative will likely be achieved during 100 Days and contains negligible risks and issues	There are known issues or risks of significance that may prevent the Commitment or Initiative from being achieved during the 100 Days but will be completed shortly after.	Based on the current situation and existing plans, the Commitment or Initiative will not be achieved

Commitment BRAG Summary					
Milestone	**BRAG for Commitment Totals**				**Overall BRAG**
	Total No. of Commitments and Count of BRAG Rating:				
DAY 1 1st July 2022	**B= 8**	**G= 0**	**A= 0**	**R= 0**	**B**
Commitment Description		**Comments**			
ICB board meeting & formal sign-off of governance documents by ICB		Complete			B
Issue Welcome Pack to residents, stakeholders & staff		Complete			B
Launch public pledge campaign		Complete			B
Staff briefing welcoming all staff into the ICB		Complete			B
Festival of Learning commences		Complete			B
Launch of ICB website and staff intranet		Complete			B
Public-facing version of 100 Day Plan to be circulated widely and made available online		Complete			B
ICB onboarding induction for all staff commences		Complete			B
	Total No. of Commitments and Count of BRAG Rating:				
DAY 30 30th July 2022	**B= 4**	**G= 0**	**A= 1**	**R= 0**	**B/A**
Commitment Description		**Comments**			
ICB board to sign off MK Deal		Framework agreed at July ICB Board, full MK Deal proposal to be taken to 30th Sept ICB Board			B
ICB directorates to hold in-person meetings		All directorates have held in-person meetings			B
ICB co-locates with Central Bedfordshire Council at Priory House and Bedford Borough Council at Borough Hall		Co-location complete			B
Co-production training for ICB staff rolled out		REVISED START DATE OCTOBER - Plan to deliver Consultation Institute training to commissioners and a Board Development session this calendar year, and then have community of practice events, led by our partners starting in the new year, so that we can share best practice while the system wide co-production strategy is being developed. The new co-production lead starts on 1 October and will take that element forward.			A
Start of engagement on strategy development		Desktop study undertaken to look at what we have been told (from across the system – including all partners) from 2019 and the Long Term Plan engagement right the way through what we've heard through Covid. We've undertaken a gap analysis on this, and we're including intelligence from that.			B
	Total No. of Commitments and Count of BRAG Rating:				
DAY 60 29th August 2022	**B= 4**	**G= 1**	**A= 1**	**R= 0**	**B/G/A**
Commitment Description		**Comments**			

100 Day Plan Progress Tracker - progress at 90 days

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Commitment BRAG Summary					
Milestone	**BRAG for Commitment Totals**				**Overall BRAG**
Health & care strategic leaders appointed			All appointments made		B
Share interim findings from Denny Review of inequalities			After involvement from system partners, engagement with communities is underway, led by Healthwatch and the VCSE. We are gathering insights and themes monthly. An Interim Report will be shared with partners in October with the final review published in December. An update will be provided in the September Live Well newsletter.		G
ICB assurance reporting for Environmental Sustainability starts			First ICB Okta submission completed in July, data provided quarterly going forward system for reporting now established.		B
Performance reporting at Place starts for all areas			The first place based reports have been produced and circulated to colleagues, the process continues to review and refine the initial reports based on place and sub system feedback.		B
Outcomes development session for system quality group			REVISED START DATE OCTOBER – Development session scheduled for System Quality Group on 26th October		A
ICB staff appraisals – new competencies			Training launched for all ICB staff		B
DAY 90 28th September 2022	**Total No. of Commitments and Count of BRAG Rating:**				G/B/A
	B= 2	**G= 2**	**A= 1**	**R= 0**	
Commitment Description			**Comments**		
Launch integrated planning process to develop 5 year Joint Forward Plan			A range of workshops on specific topic areas, starting with a focus on our strategic objective 'starting well' at the Health and Care Partnership workshop 6-8pm on 21st September at Priory House, Chicksands have been established.		G
Support development of alliance and Place longer-term plans, to ensure alignment with emerging Integrated Care Strategy			Place plans are developing and being linked to the development of the Integrated Care Strategy.		B
ICB Senior Leadership Group quarterly development session			Change of date - Development session moved to October		A
All ICB Committees have met and workplans agreed			All agenda setting and committee meetings scheduled		B
People Plan published			Change of date - Final version due to go to People Board on 20th September		G
DAY 100 8th October 2022	**Total No. of Commitments and Count of BRAG Rating:**				G
	B= 0	**G= 6**	**A= 0**	**R= 0**	
Commitment Description			**Comments**		

100 Day Plan Progress Tracker - progress at 90 days

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

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Commitment BRAG Summary

Milestone	BRAG for Commitment Totals	Overall BRAG
System reflection event & Festival of Learning successes shared	Festival of Learning developed as interactive webinar for ICB staff. Board development session in September to include reflection of the first 100 days. Case Studies being are being collected for use in System Reflection Event	G
Publish themes from pledges	Social Media pledge sharing from July, themes to be included in September board development session	G
Engagement on population health ambitions	An engagement plan is in the early stages of development to start in October.	G
Launch system efficiency and transformation programme	System efficiency - programme launched and work continuing to develop plans at system and sub system level	G
Agreement of plan for progressing the delegation of ICB activities/resources to Place	MK Deal on track for Sept ICB Board. Letter from ICB CEO sent to ICS Partners on 2/9/22 outlining the proposed next steps to align ICB activities and resources to the places and collaboratives.	G
Initial plan & approach confirmed for development of BLMK Mental Health Collaborative	Plans being socialised with partners across the ICS with the intention to bring forward a proposal to establish a collaborative having listened to partner feedback	G

ICS – Guidance published from 1st July 2022 updated 14/09/2022

APPENDIX B

Core ICS Policy & Guidance

PUBLISHED

- **Statutory guidance on Governance to ICBs** (published on FutureNHS) - Statutory Guidance on Governance to ICBs
- **Working in Partnership with People and Communities: Statutory Guidance** for Integrated Care Boards, NHS Trusts, NHS Foundation Trusts and NHS England (published on NHSE website) - Working in Partnership with People and Communities: Statutory Guidance for ICBs, NHS Trusts, NHS Foundation Trusts and NHS England
- **"Who Pays" Guidance** (published on NHSE website) - Who Pays? Guidance
- **ICB Counter Fraud Statutory Guidance** (published on FutureNHS) - ICB Counter Fraud Statutory Guidance
- **Controlled Environment for Finance** (CEfF) – various guidance (published on FutureNHS) - Controlled Environment for Finance (CEfF) Guidance 1 Controlled Environment for Finance (CEfF) Guidance 2
- **EPRR Framework** (NHSE) - EPRR Framework
- **NHS Core Standards for EPRR** (NHSE) - NHS Core Standards for EPRR
- **EPRR Annual Assurance Guidance** (NHSE) - NHS England » Emergency preparedness, resilience and response: annual assurance
- **Palliative and End of Life Care Statutory guidance for ICBs** (NHSE) - Palliative & End of Life Care: Statutory Guidance for ICBs
- **Better Care Fund** (NHSE) - NHS England » Better Care Fund planning requirements 2022-23
- **Improving cancer outcomes** (FutureNHS) - Improving cancer outcomes-guidance on how ICBs and Cancer Alliances will work together_May 2022 - ICS Guidance - Integrated Care (future.nhs.uk)
- **ICB Losses and Special Payments Guidance -** ICB Losses and Special Payment Guidance Final Approved 30 May 2022 - ICS Guidance - Integrated Care (future.nhs.uk)
- **Model ICB constitution -** Integrated Care Board: Model Constitution Template - ICS Guidance - Integrated Care (future.nhs.uk)
- **ICB constitution change request guidance -** B1650-guidance-to-integrated-care-boards-on-constitutional-change.pdf (england.nhs.uk)
- **Principles for engaging social care providers:** Adult social care principles for integrated care partnerships - GOV.UK (www.gov.uk)
- **Health and Wellbeing Board Guidance – Engagement Document -** https://www.gov.uk/government/publications/health-and-wellbeing-boards-draft-guidance-for-engagement
- **Health Overview Scrutiny Committees Principles**: https://www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles

OUTSTANDING / TBC

- **Statutory Guidance on Delegation, Joint Working & Pooled Funds -** DRAFT GUIDANCE ONLY CURRENTLY IDENTIFIED (no link available)

ICS – Guidance published from 1st July 2022 updated 14/09/2022

APPENDIX B

Supporting and Technical ICS Guidance

PUBLISHED

- **Direct Commissioning FAQ set 1** (FutureNHS) - Direct Commissioning FAQ Set 1
- **Quality Risk Response and Escalation** (NHSE) - National Guidance on Quality Risk Response and Escalation in ICSs
- **ICB commissioning of ambulance services** (FutureNHS) - ICB Commissioning of Ambulance Services
- **ICS Intelligence toolkit** - ICS Intelligence toolkit - ICS Guidance - Integrated Care (future.nhs.uk)

OUTSTANDING / TBC

- Primary Care Commissioning Assurance and Oversight Framework 2022/23 **Not yet published**
- Learning Report for clinical and professional leadership & Culture Resources (Technical Guidance) **Not yet published**
- Exec Pay Framework Guidance **To be published August/September 2022 on FutureNHS**
- A suite of short guides on specific topics drawing on best practice from advanced provider collaboratives **Not yet published on FutureNHS**
- Non-mandated documents for System Risk Management **Not yet published on FutureNHS**
- DHSC Choice Framework **Not yet published**
- SWIM (System Workforce Improvement Model) **Not yet published on FutureNHS**

Primary Care Guidance

- NHS England » Subcontract for the provision of services related to the Network Contract Directed Enhanced Service 2022/23
- NHS England » Network contract directed enhanced service indicators and SNOMED codes
- NHS England » Influenza vaccination programme: Enhanced service Seasonal influenza vaccination collaboration agreement
- NHS England » Enhanced service specification: Childhood influenza vaccination programme 2022/23
- NHS England » Enhanced service specification: Seasonal influenza vaccination programme 2022/23
- NHS England » Long COVID: Advice and resources for healthcare professionals in primary care
- NHS England » COVID-19 autumn booster and flu vaccine programme expansion
- NHS England » Securing Excellence in Primary Care (GP) Digital Services: The Primary Care (GP) Digital Services Operating Model 2021-2023

Quality

- NHS England » Patient safety learning response toolkit
- NHS England » Patient Safety Incident Response Framework and supporting guidance (various)
- NHS England » Equality Delivery System 2022 – Guidance and resources (various)

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
7. System People and Workforce

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☐	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☐	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☐	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☒	Ways of working ☐	Estates ☐
Communications ☐	Finance ☐	Operational and Clinical Excellence ☐	Governance and Compliance ☐
Other ☐ (please advise):			

What are the members being asked to do?		
Approve ☐	Note ☒	Discuss ☒

Report Author	Martha Roberts, Chief People Officer
Date to which the information this report is based on was accurate	20th September 2022
Senior Responsible Owner	Martha Roberts, Chief People Officer

Executive summary

Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board (ICB) is required to develop a People Strategy in line with the ICB's overall strategy, initially for December 2022. The ICB is required by the end of 2021/22 to:

i. Agree the formal governance and accountability arrangements for people and workforce functions in the Integrated Care System (ICS), including appointed Senior Responsible Owners (SRO).
This has been achieved.
ii. Agree how and where specific people responsibilities are delivered within the ICS.
This is achieved and defined within the terms of reference for the System People Board.
iii. Review and refresh the ICS People Board.
This has been achieved and was discussed at the last ICB Board.
iv. Assess the ICS's readiness, capacity and capability to deliver the people function.
This has been partially achieved and will be finalised with the development of the People Strategy.

This item asks for the Board's support in developing that People strategy.

ICB People Responsibilities:
Report template - NHSI website (england.nhs.uk)

1. Supporting the health and wellbeing of all staff: people working and learning in the ICS feel safe and supported in their physical and mental health and wellbeing, and are therefore better able to provide high-quality, compassionate care to patients.
2. Growing the workforce for the future and enabling adequate workforce supply: the system is retaining, recruiting and, where required, growing its workforce to meet future need. The 'one workforce' across the ICS is representative of the local communities served.
3. Supporting inclusion and belonging for all and creating a great experience for staff: people working and learning in the ICS can develop and thrive in a compassionate and inclusive environment. Issues of inequality and inequity are. The ICS people function identified and addressed for all people working in the system. The workforce and leaders in the ICS are representative of the diverse population they serve.
4. Valuing and supporting leadership at all levels, and lifelong learning: leaders at every level live the behaviours and values set out in the People Promise and make strides so that this is the experience of work for all of their 'one workforce'.
5. Leading workforce transformation and new ways of working: service redesign is enabled through new ways of working, which make the most of staff skills, use of technology and wider innovation – to both meet population health needs and drive efficiency and value for money.
6. Educating, training and developing people, and managing talent: education and training plans and opportunities are aligned and fit for the needs of staff, patients and citizens, including to enable new ways of working and support meaningful and personalised career journeys.
7. Driving and supporting broader social and economic development: leaders ensure that their organisations leverage their role as anchor institutions and networks to create a vibrant local labour market, promote local social and economic growth in the wider community, support all ICS partners to 'level up', address wider health determinants and inequalities at the heart of poor health.
8. Transforming people services and supporting the people profession: high quality people services are delivered by a highly skilled people profession to meet the future needs of the 'one workforce', enabled by technology infrastructure and digital tools.
9. Leading coordinated workforce planning using analysis and intelligence: integrated and dynamic workforce, activity and finance planning meets current and future population, service and workforce needs, across programme, pathway and place.

10. Supporting system design and development: the system uses organisational and cultural system design and development principles to support the establishment and development of the integrated care board (ICB), and the integrated care partnership (ICP). The organisational development approach creates a system-wide culture that: is driven by purpose; enables people, places and the system to fulfil their potential; is connected to the people served by the system and those delivering services; The ICS people function harnesses the best of behavioural, relational and structural approaches; and nurtures collaboration.

In support of the delivery of the ten workforce areas the ICBs are responsible for, the system People Board has agreed a People Plan. The Board is asked to note the People Plan and the actions within it intended to mitigate workforce risks in the control of the ICB.

The Board is asked to note that Bedfordshire, Luton and Milton Keynes, (BLMK) system faces a number of challenges relating to workforce and these form the basis of our 2022/23 priorities addressed in the People Plan:

- Vacancies: An issue in all services. Particularly challenging in mental health and community services, social and primary care and many specialties within acute Trusts such as midwifery.
- Demographics: Including aging GPs, nursing and consultant workforce.
- Transformation of Services: Integrated Planning will mean changes to how services are provided which will have significant workforce impact.
- Retaining and developing talent: The system does not retain enough of the people who study in BLMK or join a system organisation. Our leadership does not reflect the make-up of our workforce or population.
- Sustainable workforce supply: Currently not enough of our population choose health and care careers causing a reliance on temporary staffing solutions which is not sustainable.
- Contributing to the economic and social development of BLMK: The ICS needs to fulfil its role as an anchor institution in promoting the economic and social health of BLMK.
- Working as a system: Developing behaviours and structures that enable the system to work together collaboratively and effectively. Issues such as the availability of estate in Primary Care, introduction of new technology and ensuring the environmental sustainability of services will take co-operation across the system, using neighbourhood and place to drive development of a population health-based development of services.

Workforce is the highest scoring risk on the Board Assurance Framework (20).

A key area of the People Plan is addressing inequalities. The Board is asked to note the update on the Workforce Race Equality Standard (WRES).

What are the available options?

Not Applicable

Recommendation/s

1) The Board **note** the positive progress of the People Board against national guidance and expectations for 21/22.
2) The Board **agree** to the development of a People Strategy for the ICB in line with the ICB Strategy for December 2022.
3) The Board **note** the People Plan signed off by the System People Board.
4) The Board **note** the Workforce Race Equality Standard update.

Key Risks and Issues

1) That we don't realise the potential of system level work on workforce and do not enable potential barriers to movement of colleagues between employers to be removed. Projects at system level can be done to benefit partners when they may not do that work themselves due to economies of scale.
2) That we don't implement best practice in the recruitment and retention of our colleagues to the benefit of the populations we serve. System led projects on inclusive recruitment will support our employers to adopt best practice.
3) That we don't use the influence of the system partners as anchor institutions to reduce local inequalities and boost a local workforce approach across BLMK and creating an attractive place to work in a competitive employment marketplace.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐

All the People / workforce Risks are currently being transferred onto 4Risk. The use of the 4Risk system for the People Board's management of Risk was discussed by the People Board on 20th September 2022 and supported. This will align the 'People' risk management with the ICB Board's other risks and support the theme of 'workforce risks' to be connected and understood across the Board's priorities. The People Plan supports the mitigation of these risks.

Are there any financial implications or other resourcing implications?

The programme of work in the People Plan is currently funded by programme monies from NHS England and Health Education England. The project-based nature of the funds means a piecemeal approach to the work, but it is funded. This method of funding requires additional support from Finance colleagues. At a future stage it is likely to Board of the Integrated Care Board will need to review and discuss a sustainable approach to funding the System People work. Health Education England and NHS England are developing their future operating model currently, depending on the outcome of that work, ICBs may be asked to host delegated functions. Should this happen, a full due diligence process will take place to assure the Board's liabilities and opportunities.

How will / does this work help to address the Green Plan Commitments?
Click to view Green Plan

By training and employing people who live locally we are reducing the impact of travelling to get to work.
By working with transformation programmes, we are developing digital skills in our workforce.
By creating local employment, we are providing incomes to local people, supporting them to have healthier and better lives.

How will / does this work help to address inequalities?

By creating fair and equal opportunity-based employment and development of careers, the system partners can, through their People Plan, target, and support the reduction in inequalities by firstly developing and creating employment opportunities for all our population and ensuring fair development is possible.

The following individuals were consulted and involved in the development of this report:

The Bedfordshire, Luton and Milton Keynes People Board is made up of all partners in the ICB. Each element of the People Plan has a Senior Responsible Officer from a system organisation. They discussed and agreed the attached People Plan on 20th September 2022 and had time before the 20th to comment and review the People Plan.

Next steps:
The Board will receive: 1) A People Strategy for the ICB in line with the ICB strategy, initially for December 2022 2) Regular updates from the People Board on their work programme and mitigation of risks including equality, diversity and inclusion
Appendices
Appendix A – Bedfordshire, Luton and Milton Keynes People Plan September 2022 Appendix B – Workforce Race Equality Standard Report Appendix C – BLMK Workforce Bitesize Report

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

APPENDIX A
Bedfordshire, Luton and Milton Keynes
Integrated Care System

People Plan 2022/2023 Sept 2022

Approved

01 Contents

02 Introduction

The ICS People Plan sets out the vision, aims and key actions for how the system can work together to deliver the ICS's strategic objectives while also meeting its responsibilities to its staff, volunteers and learners.

The 2022/23 People Plan is for all ICS organisations including local government, the care sector, charities, the NHS and voluntary and community enterprises

03

Part A: Context, Vision, Priorities & Actions

04 Context

How health and social care is organised and delivered is changing. Changing technology, demographic changes in our populations mean that the current approach to providing and staffing services needs to change. A more person centred, integrated and data driven approach is required.

There are substantial workforce challenges around vacancies, demographics, pipelines of staff and our ability to support and develop our learners, workers and volunteers.

National policy in health and care, such as the recent Ockenden* report into maternity services, the Messenger Review**, the Fuller*** review of Primary Care and Cavendish Report**** into Adult Social Care all impact on the services and workforce required by the system.

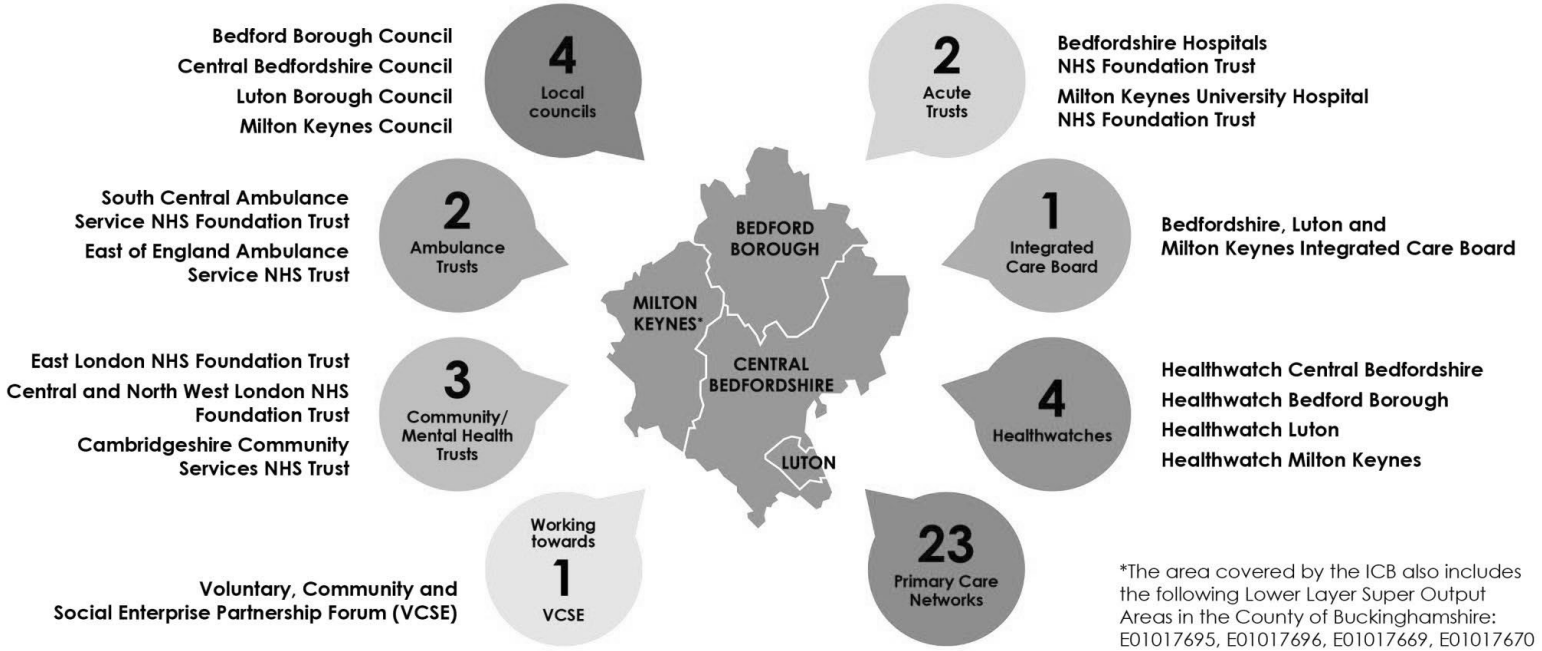
The establishment of ICSs as statutory bodies in July 2022 provides opportunities for organisations operating in Bedfordshire Luton and Milton Keynes (BLMK) to work together to address some of these challenges and improve outcomes for our populations and workers.

05

Our partners

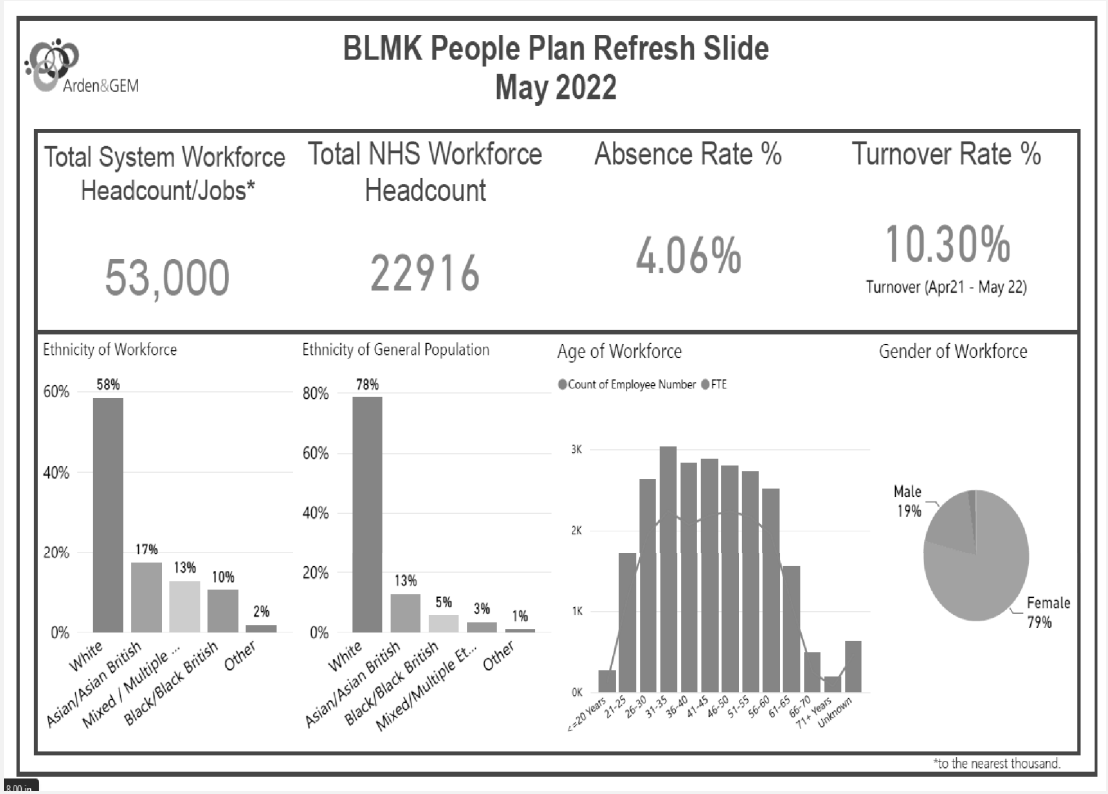
Our partners include the local councils in our area, four Healthwatches, NHS organisations such as hospital, community, mental health and ambulance trusts, 27 Primary Care Networks made up of the 95 GP practices in our area and the voluntary and community sector.

Proud to be working together for better, more integrated services in Bedfordshire, Luton and Milton Keynes Integrated Care System



*The area covered by the ICB also includes the following Lower Layer Super Output Areas in the County of Buckinghamshire: E01017695, E01017696, E01017669, E01017670

06 Our Workforce



BLMK has a relatively young and diverse workforce compared to the EoE, however this masks significant local variation. The ICS has challenges around: recruitment, retention, wellbeing and ensuring that the leadership of our organisations reflect the communities they serve and the workforce they represent.

07 Workforce Challenges

BLMK faces a number of challenges relating to workforce and these form the basis of our 22/23 priorities:

- **Vacancies:** An issue in all services. Particular challenge in mental health and community services, social and primary care and many specialties within acute Trusts such as midwifery
- **Demographics**: Including an aging GP, nursing and consultant workforce
- **Transformation of Services:** Integrated Planning will mean changes to how services are provided which will have significant workforce impacts
- **Retaining and developing talent:** The system does not retain enough of the people who study in BLMK or join a system organisation. Our leadership does not reflect the make up of our workforce or population.
- **Sustainable workforce supply:** Currently not enough of our populations choose health and care careers causing a reliance on temporary staffing solutions which is not sustainable.
- **Contributing to the economic and social development of BLMK:** The ICS also needs to fulfil its role as an anchor institution in promoting the economic and social health of BLMK.
- **Working as a system:** Developing behaviours and structures that enable the system to work together collaboratively and effectively. Issues such as the availability of estate in Primary Care, introduction of new technology and ensuring the environmental sustainability of services will take co-operation across the ICS.

08 Our Vision

Our vision is simple;

To make the BLMK system an attractive place to work, learn and live

09 Guiding Principles

In developing priorities and actions for the system the following principles will inform our approach:

- The system is all organisations, social care, the NHS, VCSE and other partners supporting our goals.
- Equality, inclusion, belonging and the reduction of inequalities needs to run through all our work
- Ensuring People Board actions help to deliver the ICS's strategic priorities
- Subsidiarity: doing things as close to those affected as possible and at scale when it delivers benefits
- One workforce: implementing solutions that focus on outcomes for staff and residents and not organisations

10 Our Objectives

The Key areas of focus have provided the impetus for the People Plan's objectives:

- Ensure sufficient supply and retention of trained and engaged workforce to provide services to our population.
- Ensure careers in health and care are accessible, fair and equal and support people with their own mental and physical health.
- Innovate in the roles we offer, flexible in how they are done and embrace technology and data to drive decision making to ensure efficient use of public funds.

Through the achievement of these objectives we will support economic growth for BLMK and reduce inequalities for our populations and those who work in our system.

11 Priorities

Following engagement with stakeholders the People Board has established the following priorities for 22/23:

- Development of an integrated workforce planning approach linked to ICS strategic plan utilising accurate and timely workforce data
- Supporting the wellbeing and career development of our staff across health and care
- Promoting diversity in our workforces and leadership teams
- Developing short and long term pathways for our populations to enter and thrive in health and care careers
- Support the development of new roles, joint roles across health and social care and apprenticeships at scale, leveraging anchor institution status
- Effectively use temporary staffing resources, ensuring best value and maximum impact for the system
- Developing the organisational development (OD) capacity across the system to make sure the changes required by integrated care delivery are embedded successfully

12 Key Actions (1)

Priority	Actions	Impact
Integrated Workforce Plan for the ICS	Improved workforce data across health and care, development of integrated planning approach involving whole system	Creation of workforce strategy to guide future work
Wellbeing & Career development	Access to digital and in person wellbeing resources, career progression between health and care, leadership training and development, talent management, register of social care training resources	Reduced turnover, reduced sickness absence, improved staff survey results
Promoting diversity	'No more tick boxes' to reform recruitment, leadership opportunities for BAME staff, promotion of staff networks, attracting staff from non-traditional backgrounds into roles	Improved WRES & WDES data, more diverse leadership

13 Key Actions (2)

Priority	Actions	Impact
Pathways into careers	Outreach to education institutions, innovate recruitment approaches, overseas recruitment, increasing placement capacity, improved pastoral support for new starters, use of levy	Reduced vacancies and turnover in new starters
Development of new and joint roles in health and care	Rotational apprenticeships, virtual wards, legacy roles	Reduced turnover, reduced sickness absence
Use of temporary staffing resources	Reservists, in health and care sharing of agency rates, agency caps, e-rostering	Reduced agency usage and spend
System OD capacity	ICB board development, building community of practice	Reduced turnover

14 Measuring Impact

The impacts of the People Board's actions will be monitored through metrics agreed in March 22 and reported through a dashboard using statistical process control.

Metric	Target
Sickness absence	Statistically significant improvement month on month compared to 21/22 monthly figures
Vacancies (WTE)	Statistically significant improvement March 23 compared to April 22
Turnover (%)	Statistically significant improvement March 23 compared to April 22
Staff engagement score (staff survey/equivalent non-NHS)	Statistically significant improvement 2022 compared to 2021 scores
Staff Survey (equal career progression)	Statistically significant improvement 2022 compared to 2021 scores

Part B: Alignment to system, regional and national priorities across health and care

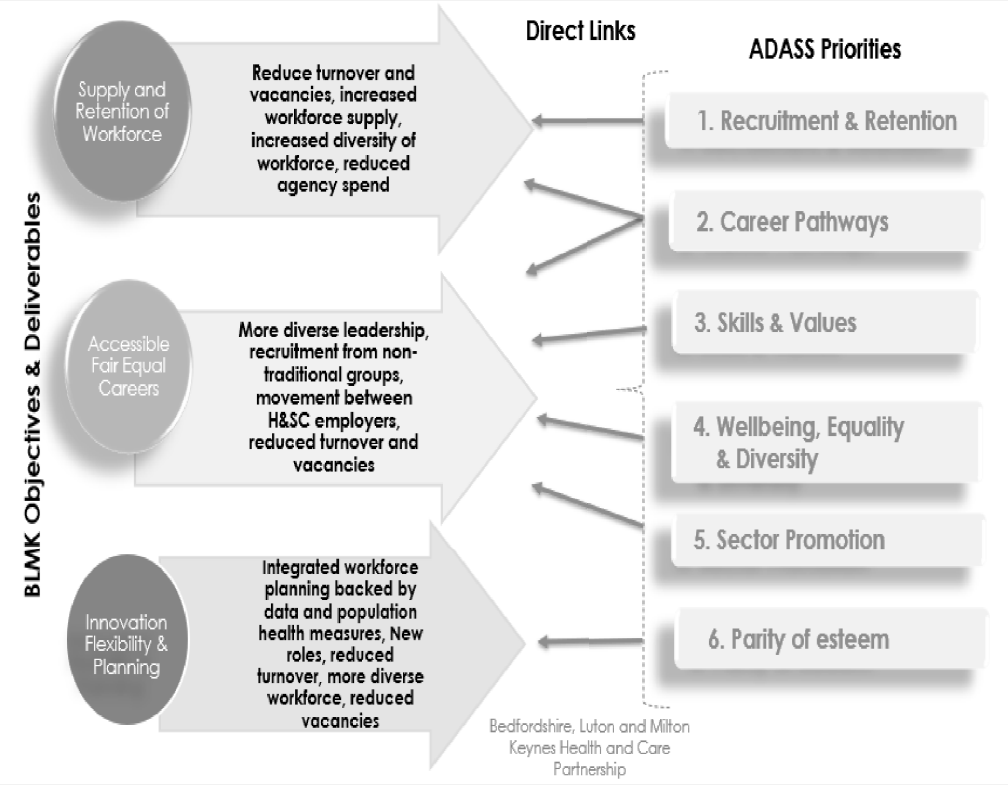
16 Enabling ICS Strategic Objectives

Examples of current work contributing to the ICS's priorities

01 Start Well	02 Live Well	03 Age Well	04 Growth	05 Reducing Inequalities
• International Recruitment Legacy role pilot in midwifery • Increased placement capacity • Recruitment into Children's centres • Providing volunteering and education opportunities for communities	• Wellbeing initiatives: wellbeing hub, shiny minds app, flexible working • Wellbeing conversations and awareness • Rewarding careers btw health and social care • Employment as a driver of improved health outcomes	• Launch of reservist model • 'Legacy' role pilots to retain skills of experienced staff • Support for workers wishing to retire flexibly • Closer working with VSCE to provide volunteering opportunities • Flexible care roles	• Improving use of apprenticeship levy • Working collaboratively to encourage new workforce into health and social care • Improving pastoral support for new starters in the system • Developing new roles and embracing digital • Joint recruitment between health and social care	• EDI networks established at system level and in organisations • Leadership and development • Providing new routes into employment for underrepresented groups • Working collaboratively as anchor institutions on apprenticeship levy

Service re-design and ensuring sufficient workforce is recruited and retained to be able to provide services to the population

17 Alignment to ADASS Priorities



There is a significant overlap in the objectives of the People Board and those outlined in the Association of Director of Adult Social Services(ADASS) Eastern Regional Workforce Strategy.

Maintaining and deepening the links between health and social care is vital to the success of the People Plan.

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Alignment to National People Plan

The People Plan priorities provide a framework for ongoing and planned actions to address BLMK workforce challenges:

Looking After Our People	•Retention challenges across Health and Social Care •Burnout amongst health and social care staff •A lack of flexibility in working patterns, roles and career development •Providing engaging and rewarding roles for our populations •Enabling people to speak out and influence their working lives
Belonging in BLMK	•A lack of diversity in senior leadership roles •Attracting a diverse range of candidates •Promoting parity of esteem between health and social care •Developing a positive 'system' focussed culture
New Ways of Working	• Needing to be more efficient with the resources we have • The potential of new roles and ways of working not always fully realised • Reducing organisation level boundaries for staff looking to develop their careers • Greater involvement and use of third sector providers • Significant changes to how services are provided requiring a OD support
Growing for an Integrated Future	•Reducing vacancies across all organisations •Challenge of expanding placement capacity and working with HEIs to ensure workforce pipeline •Leadership and talent management to develop and retain staff •Maximising the benefit to the population, staff and the economy of our status as anchor institutions •Undertaking research in partnership with our universities

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Alignment of Priorities and Actions

The People Plan actions are aligned to a number of national, regional and system priorities

ICB People Responsibility	People Plan Priority	Future of HR & OD Actions	ICS Strategic Priorities	Current and Planned Actions
1. Supporting the health and wellbeing of all staff	Looking after our people	Actions 13 & 15: Prioritising the health and wellbeing of all our people & Actions 21 and 24: Creating a great employee experience	People are supported to engage with and manage their health and wellbeing (2) In everything we do we promote equalities and in the health and wellbeing of our population (5)	- Wellbeing hub launched and expanded - Shiny Mind app lauched and being expanded in Primary Care and Acute Trusts and HALO project commenced to improve wellbeing for staff and patients - Primary Care Health and Wellbeing pilot launched - Wellbeing and flexible working discussions embedded in NHS provider appraisal discussions - Wellbeing workstream at People Board from 22/23 and wellbeing network group established
2. Growing the Workforce for the future and enabling adequate workforce supply	Growing for an Integrated Future	Actions 21 and 24: Creating a great employee experience	We work together to build the economy and support sustainable growth (4), People age well, with proactive interventions to stay health, independent and active as long as possible (3)	- 50k Nurse recruitment programme - International recruitment of nurses & GPs expanding into other professional groups - Placement capacity expansion programmes with Primary Care and acute settings - Work learn live website advertising roles across health and social care - Anchor institution work focussing on engagement with schools, colleges and NEET - Reservist model being launched to retain mss vax workforce and grow engagement with system
3. Supporting inclusion and belonging for all, and creating a great experience for staff	Belonging in the NHS	Action 17 & 18: Ensuring inclusion and belonging for all	In everything we do we promote equalities and in the health and wellbeing of our population (5), People age well, with proactive interventions to stay health, independent and active as long as possible (3)	- System EDI network launched - Recruitment of system EDI role for 22/23 - Leadership programmes and development opportunities for BAME staff - Delivery of EoE Anti-racism strategy; particularly reforms of recruitment processes

20 Alignment of Priorities and Actions

ICB People Responsibility	People Plan Priority	Future of HR & OD Actions	ICS Strategic Priorities	Current and Planned Actions
4. Valuing and supporting leadership at all levels, and lifelong learning	Belonging in the NHS	Action 29: Harnessing the talents of all our people	In everything we do we promote equalities and in the health and wellbeing of our population (5)	- Rotational apprenticeship programmes - Leadership programmes in association with Leadership academy - Creating a bank of coaches for the system - Developing a consistent approach to talent management across the system
5. Leading workforce transformation and new ways of working	New ways of working	Action 6: Leading Improvement, change and innovation & Action 8: Embedding digitally enabled solutions	In everything we do we promote equalities and in the health and wellbeing of our population (5)	- ACP support in Primary Care - Enhanced collaborative Bank arrangement - eRostering levels of achievement improvement - New roles in Mental Health and Primary Care trials - Training on new ways of working e.g. digital consultations in Primary Care - Support for system transformation projects e.g. Mental Health workforce and diagnostic workforce
6. Educating, training and developing people, and managing talent	Growing for an Integrated Future & Looking After our People	Actions 2 & 3: Supporting and developing the people profession	In everything we do we promote equalities and in the health and wellbeing of our population (5)	- Directory of Care for social care providers - Primary Care mentorship programmes, coaching and early career support - Rotational apprenticeship pilot in Bedfordshire

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Alignment of Priorities and Actions

ICB People Responsibility	People Plan Priority	Future of HR & OD Actions	ICS Strategic Priorities	Current and Planned Actions
8. Transforming People Services and supporting the people profession	New ways of working	Action 6: Leading Improvement, change and innovation & Action 8: Embedding digitally enabled solutions	People age well, with proactive interventions to stay health, independent and active as long as possible (3)	- Digital passports for staff - Collaborative Bank work - HR Graduate Trainees system placements in 22/23 - Streamlining recruitment processes for IR recruitment and joint recruitment campaigns
9. Leading coordinated workforce planning using analysis and intellegence	New ways of working & Growing for an Integrated Future	Action 6: Leading Improvement, change and innovation & Action 8: Embedding digitally enabled solutions	All 5	- System and regional investment in workforce planning capacity - Piloting integrated planning approach in system and region
10: Supporting system design and development	New ways of working & Growing for an Integrated Future	Action 6: Leading Improvement, change and innovation & Action 8: Embedding digitally enabled solutions	All 5	- Working with PCNs, alliances and places around where delivery of workforce objectives is best provided - Working with regional teams on establishment of people function and resource within ICS

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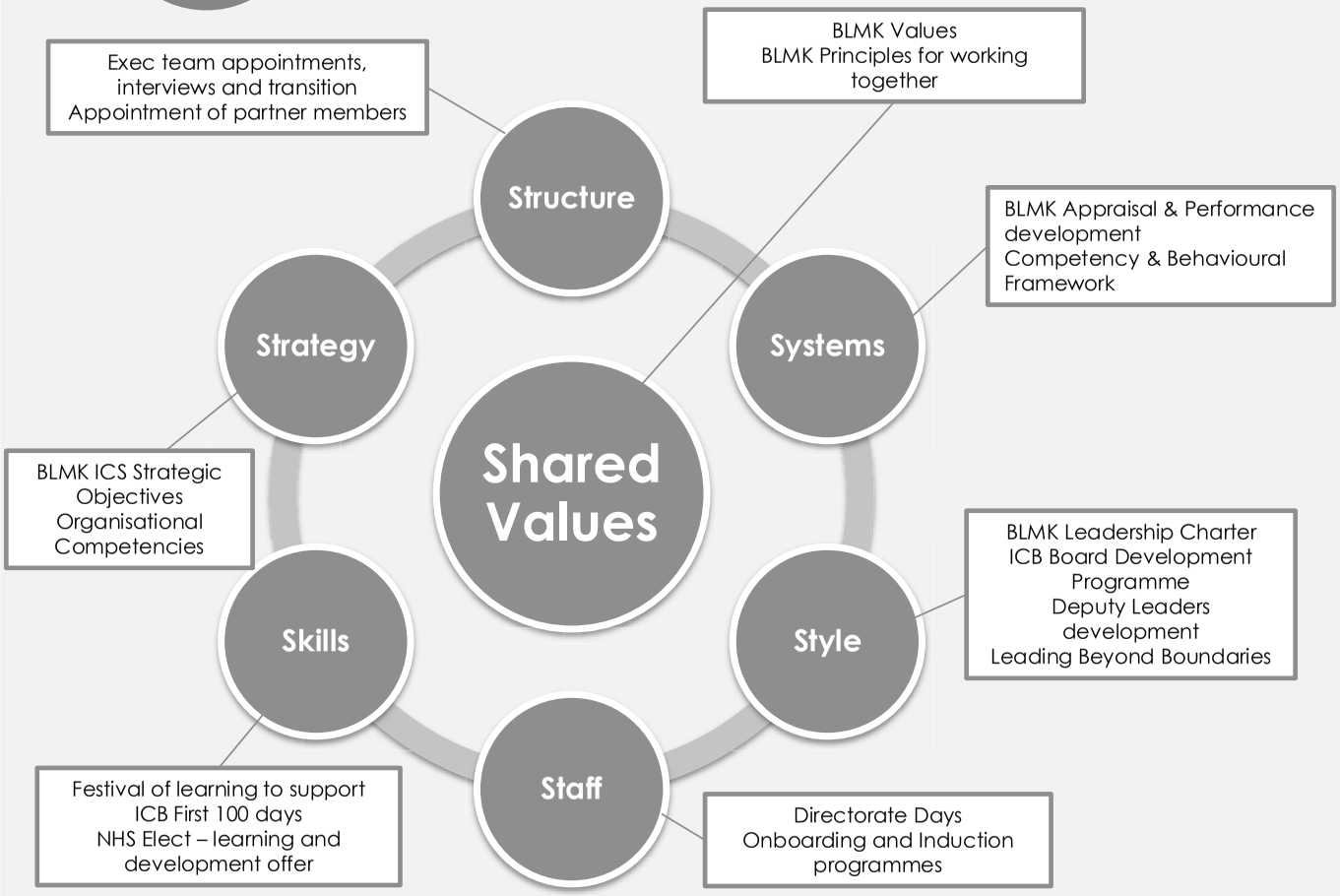
Part C: Organisational Development

23 Organisational Development

Delivering the commitments outlined in the People Plan, to both improve the people profession and support the substantial changes to how services are provided requires a planned, system wide effort that enables individuals, teams and organisations to thrive in a ever changing operating landscape

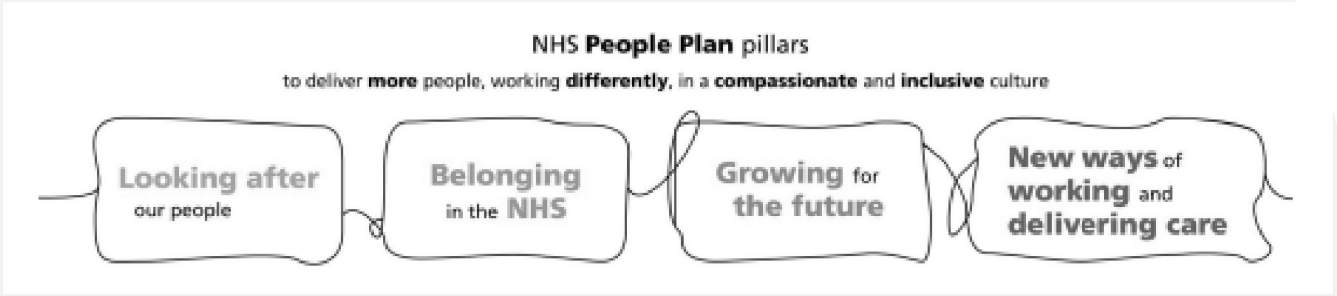
- The transition into an integrated care system across BLMK will change how services are received by our populations and delivered by our staff
- This represent a shift from the current operating model requiring constituent parts of our system to be integrated, working in collaboration and in a partnership approach.
- During 22/23 an OD Strategy for the ICS will be developed, building on current ICB focused work. This will be done in conjunction with partner organisations. This will help to address system challenges including requirements of national reviews such as the Fuller Review***
- The system can build on its shared values and new ways of working to support the delivery of improved outcomes for our population through our new ways of delivering care. This is important because;
  - Our workforce needs the skills to lead service improvement, work across boundaries, work with patients in an integrated manner and to push ahead with digital innovation.
  - Greater integration of services and more personalised and preventative care will erode organisational silos and support a more 'one workforce' approach to have services are staffed
  - Our leaders require support in helping them develop this growth mindset across our organisations and to be supported in embracing the new ways of leading/working
  - We can ensure sustainable change by ensuring our staff and volunteers are engaged with the process

Organisational Development Plan for the ICB



- There are many different OD models but the McKinsey 7S model has been identified as framework that aligns activities of the OD Plan
- This includes Structure, Systems, Style, Staff, Skills, Strategy and Shared Values which ensures that as a new organisation the ICB is developed thoroughly and at each level i.e. individual, team, organisational and system.
- Key organisational development activities, identified as essential for the development and growth of the ICB have been aligned to the 7S model is outlined here
- Delivery of our OD plan will help to align people, strategy and process across the ICB and in doing so will support organisational change, revitalisation and develop capacity

25 OD Plan: Delivering Outcomes



Our deliverables sets out to enable the four elements of the NHS People Plan

Key Deliverables 2022-23

Development of co-production training module to develop skills across our workforce in integrated partnership working across the ICS	Delivery of ICB Board development designed around key skills and behaviours for an integrated care approach	Alignment of local designed values with BLMK system values providing common ground for co-operation to achieve shared aspirations, across the system	The co-design of OD interventions takes into account national reviews (Fuller Report, Messenger Review by supporting people working in new ways together and breaking barriers	Our leadership development programme emphasises learning on the role of ICSs as vehicles for change to tackle health inequalities, enhance productivity and broader social and economic development.	The ICB is championing a Festival of Leaning to support the First 100 days programme to develop an organisational culture of learning and improvement

Our OD Plan sets out key deliverables to support transformation

BLMK OD Plan

Structure Systems Staff Style Skills Strategy Shared Values

Part D: Governance and Principals

27 Governance

The delivery of the People Plan is monitored through the BLMK People Board. The Board will change during 22/23 to take into account the expanded role of the ICS as a statutory body and its role in delivering the People Plan:

- New terms of reference to focus more on diagnosing and tackling the strategic workforce challenges facing the ICS
- Refreshed membership to expand participation beyond HR professionals to those leading system transformation
- Refreshed and expanded sub group structure to give greater profile to health and wellbeing and EDI
- New metrics, targets and reporting methodologies agreed by system partners

28 People Board Structure & Work Streams

BLMK ICB

National People Board

EoE Regional People Board

BLMK People Board

Health and Wellbeing Equality, Diversity and Inclusion

- Wellbeing Hub
- Flexible Working Expansion
- Establish a Health and Wellbeing network
- Improving access to psychological support
- Supporting Primary Care with access to wellbeing and anti-bullying
- Implementation of anti-racism strategy
- Establish and EDI network in BLMK
- Leadership programmes for BME staff development e.g. Stepping up
- Developing development programmes for all groups e.g. access to work for differently abled
- Supporting organisational network with development, Start-up and training

Leadership & talent management

- Leadership development with a system perspective
- Talent management looks across the system
- Organisational development support office

Education and Training

- Rotational apprenticeships and a system wide approach to training
- Engagement with HEIs and HEE around placement capacity
- Specific projects such as Home Based Care Directory or harmonisation of volunteering training

Workforce modelling, supply and transformation

- 50k nursing recruitment and retention
- Transformation Projects e.g. flexible bank and diagnostic workforce
- Recruitment fairs, website, novel recruitment methods

Primary Care Training Hub

- Elements of all other work streams as they relate to PC
- Delivery of HEE PCTH requirements as per contract

A ‘One Workforce’ approach

The ‘one workforce approach’. The model below describes three stages of workforce integration. The level of integration required and the timeframes for integration will be determined by the service and place needs.

Collaboration:
Performing tasks or activities jointly to achieve place/system objectives more effectively than organisations alone

Partnership:
Formal relationships between organisations which depend on each other to provider services

Integration:
Merger of services/teams. Place and not organisational as the basic unit of the ICS

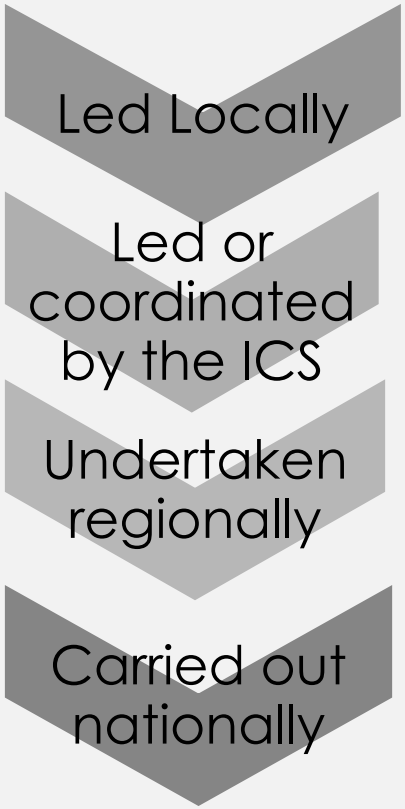
How we work as a system

There are differences in the workforce interventions needed to support population health improvements in different parts of the system.

Based on the principal of subsidiarity, decisions and actions are taken at the most appropriate level for the system.

There is alignment against key themes and priorities between the BLMK People Plan, place and organisational plans but they are adaptable to local conditions.

31 Principal of Subsidiarity



- Activities relate directly to the employment, development, morale, wellbeing and retention of the people who work in that local organisation
- Multi-disciplinary teams at PCN/Place level using 'one workforce' principals aligned to place/alliance/ICS priorities.

- strong local partnerships are required, including partnerships with local government, social care and education organisations
- planning is needed over a medium-term period (e.g. up to five years)
- decisions need to be made across a local labour market
- there are benefits of scale from joined-up solutions to shared challenges

- there is a need for coordination and improvement support to deliver national priorities
- there is a need to help foster capacity in local health systems
- decisions need to be made across a regional labour market

- It is necessary to meet statutory responsibilities
- it is more efficient and effective because of economies of scale and there are benefits from a national role in standardisation or implementation
- national teams have specific and scarce skills/knowledge that ICSs and local organisations can draw on.

The principal of subsidiarity will guide where activities will be undertaken, at system, alliance, place or organisational level. Decisions to be taken at as local a level as possible.

Part E: Appendices

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Key Dates 22/23

Q1/2 22/23

- Agree Metrics, targets & terms of reference for People Board
- Devolution of functions from regional/national NHS teams e.g. CPD and demand scoping work
- 22/23 annual plan submission and monitoring
- ICB establishment in July 2022 and changes to People Board membership, updated ToR and responsibilities
- Determining People Board's place in wider ICB governance structure
- Determination of People Board priorities and priority actions
- Approval of People Plan for 22/23 (September 22)

Q3/4 22/23

- Development of Long Term ICS Workforce Strategy covering health and social care alongside Integrated Care Strategy
- Further development of places and boards and their role in delivering workforce actions
- Reduced silo working in and between organisations with reduction of barriers to workforce movement and joint working
- Greater co-operation between health and social care on commissioning academic placements, recruitment, career development and planning and involvement of workforce colleagues from local government beyond social care

2023/24 and beyond

- Iteration of ICS People Plan for 23/24 linked to objectives in Long Term ICS workforce strategy
- Implementation of integrated planning approach
- People Board takes a growing role in the setting of objectives for the system and assurance of their delivery
- Vision of 'one workforce' begins to become reality for staff
- Review of effectiveness of governance arrangements, ToR and membership of People Board

35 References

- * Ockenden Report
- ** The Messenger Review
- *** Fuller Review of Primary Care
- **** Cavendish Report into adult social care

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

APPENDIX B

Workforce Race Equality Standard (WRES) update

The WRES

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS Standard Contract. In April 2015, after engaging and consulting with key stakeholders including other NHS organisations across England, the WRES was mandated. From 2017, independent healthcare providers were required to publish their WRES Data. WRES data is collected through the SDCS portal from Staff Record data. There is also information gathered from Staff Survey results.

The 2021 WRES data report compares data from previous years to assess trends. NHS providers are expected to show progress against nine indicators of workforce equality, including a specific indicator around appointment of BME staff, the numbers of BME staff facing disciplinary compared to their white counterparts and to address the low numbers of BME board members across the organisation.

The first phase of the WRES focused on supporting the system to understand the nature of the challenges of workforce race equality and for leaders to recognise that it was their responsibility to help make the necessary changes.

The next phase of the WRES will focus on enabling people to work comfortably with race equality. Through communications and engagement, we will work to change the cultures of race inequality in the system, learn more about the importance of equity, to build capacity and capability to work with race. Continuously embedding accountability to ensure key policies have race equality built into their core, so that eventually workforce race becomes everyday business.

The Equality, Diversity, Inclusion and Belonging sub-group of the ICB will hold the programme of work on this. We are investing in E,D and I and anti-racism posts so will be able to support a programme of work, linked with NHS England East Region's anti-racism strategy, to which we are a signatory. We are developing a proposal for reciprocal mentoring as well.

The WRES in BLMK

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

- WRES Data is held, monitored and acted upon by each NHS organisation individually in BLMK.
- Organisations may produce a Report, Recommendation and Action Plan informed by the WRES data
- There has not been an appropriate setting to regularly monitor and develop these plans at system level. With the introduction of the Wellbeing and EDIB board as a sub group of the People Board we hope to work more closely and at a systems level.
- Local Authority partners currently do not produce an equivalent data set, there are some national pilots of WRES in local authorities and we are finding out how that might work for us.

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

Indicator Examples

The following are examples of BLMK Organisations performance taken from the March 2021 WRES data

Indicator 2- Relative Likelihood of White Staff being appointed from shortlisting compared to BME Staff

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Relative likelihood- How much more likely is it that a white candidate will be appointed. For example, if the relative likelihood 2.0 this means a white candidate is twice as likely to be appointed than a BME counterpart.

Trust Name	White: Likelihood of being appointed from shortlisting	BME: Likelihood of being appointed from shortlisting	Relative likelihood of white candidates being appointed from shortlisting compared to BME candidates
Bedfordshire, Luton and Milton Keynes CCG	**23%**	**10%**	**2.31**
Bedfordshire Hospitals	**7%**	**5%**	**1.25**
Cambridgeshire Community Service	**46%**	**26%**	**1.75**
Central and Northwest London	**23%**	**15%**	**1.47**
East of England Ambulance Service	**16%**	**6%**	**2.59**
East London Foundation Trust	**26%**	**21%**	**1.22**
Milton Keynes University Hospital	**25%**	**19%**	**1.29**

Data Source: Workforce Race Equality Standard 2021 SDCS returns

Indicator 9-Board Representation Voting

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Indicator 9 aims to show the percentage of Board members by ethnicity compared to BME workforce within the trust. Highlighting how this is represented across voting and non-voting members.

Trust Name	Workforce Overall			All Board Members			Voting Board Members			Non-voting Board Members		
	White	BME	Null	White	BME	Null	White	BME	Null	White	BME	Null
Bedfordshire Hospitals	**53.2%**	**43.3%**	**3.6%**	**90.0%**	**10.0%**	**0.0%**	**93.8%**	**6.3%**	**0.0%**	**75.0%**	**25.0%**	**0.0%**
Cambridgeshire Community Service	**82.5%**	**12.0%**	**5.5%**	**92.3%**	**7.7%**	**0.0%**	**92.3%**	**7.7%**	**0.0%**	**-**	**-**	**-**
Central and Northwest London	**29.6%**	**62.9%**	**7.5%**	**56.3%**	**43.8%**	**0.0%**	**54.5%**	**45.5%**	**0.0%**	**60.0%**	**40.0%**	**0.0%**
East of England Ambulance Service	**82.4%**	**3.4%**	**14.1%**	**92.3%**	**0.0%**	**7.7%**	**90.9%**	**0.0%**	**9.1%**	**100.0%**	**0.0%**	**0.0%**
East London Foundation Trust	**46.3%**	**52.0%**	**1.6%**	**47.4%**	**52.6%**	**0.0%**	**47.1%**	**52.9%**	**0.0%**	**50.0%**	**50.0%**	**0.0%**
Milton Keynes University Hospital	**61.0%**	**34.0%**	**5.1%**	**94.1%**	**5.9%**	**0.0%**	**92.9%**	**7.1%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**

*Bedfordshire, Luton and Milton Keynes Integrated Care Board not included as the organisation was not formed till after this data was taken

Data Source: Workforce Race Equality Standard 2021 SDCS returns

APPENDIX C

BLMK Workforce Bitesize

Activities and Impact: September 2022

BLMK Integrated Care System

People Board

The September People Board was chaired by the ICS's new Chief People Officer (CPO), Martha Roberts and incorporated many of the changes to terms of reference agreed in July. The board also built on the work of the May and July with a facilitated discussion, led by Innovate for Action (IA) of Integrated Planning and how this might be achieved by the system. This is a key priority for the board.

The Board also agreed to adopt 4Risk as the new risk management system and align People Board risks to ICS system risks monitored by the ICB

Workforce Modelling, Supply & Transformation

Exec Lead: Danielle.Petch@mkuh.nhs.uk

Key achievements:

National 50k Nurse programme: Programmes continue to outperform targets for total nurse growth in system at 2.9%.2nd lowest attrition rate at 7.4%(compared to regional average of 8.90%)

International Nurse Recruitment is the main supply pathway for Nursing growth for BLMK with a steady growth above HEE Trajectory. If additional funding given by NHSEI a further 30WTE to the planned 223 WTE in 2022. 55% of planned staff have arrived in the Trusts. Challenge with OSCE availability improvement since escalation process with NMC.

IR Nurses Career Coaching: Career Coaching Lead held very well attended (70 attendees) IR Nurses Forum in June. Next Forum September. Partnership working with H&WE to bid for funding to implement digital resource app.

HCSW Ongoing recruitment and retention initiatives in place

Impact (for staff & residents): Improving workforce supply for NHS organisations as a result of initiatives and pilots.

Next Steps: Legacy roles (Midwifery and AHP due to start September, Nursing –application for additional funding). Engagement with partners of Phase one of Reservist model. HCT fully funded reservists for August/September.

Education & Training

Exec Lead: Kate.Howard4@nhs.net

Key achievements:

Personalised Care: Funding received for training for secondary and community care; work underway to design the offer with Keech Hospice

Community Upskilling Bid: Successful in securing £106k for upskilling health and social care colleagues. Funding expected in October. Aim to free to up qualified staff to work at the top of their licence to support system flow and resilience.

BLMK Apprenticeship Strategy: Implementation plan now drafted and to be discussed at next Apprentice Leads Network meeting on 25 October.

Demand Scoping/Education Planning: WDA team supported this process, usually completed directly between providers and HEE, for the first time this Summer as part of the move to transfer some HEE functions to ICS teams. High engagement from providers and positive feedback from HEE. Work now being completed on the final queries raised by HEE, prior to moving to the next stage in the process.

Impact (for staff & residents):

Staff awareness of personalised care and its importance to BLMK residents receiving care and support is raised and more person-centred care is planned and delivered.

Staff are upskilled to support local residents and have more opportunities to develop

Next Steps: Additional personalised care training to be designed and promoted to staff. Roll out of community upskilling initiatives.

Workforce Bitesize

Activities and Impact: September 2022

BLMK Integrated Care System

Leadership & Organisational Development: Exec Lead: Anita.Pisani@nhs.net:

Key Achievements:

Bedfordshire Peer Learning Network: relaunching in September with a seminar on Early Talent Engagement. Speakers for this session are drawn from the Luton Careers Hub and the Bedfordshire Fire and Rescue Service.

ICB Competencies: will commence a roadshow to take these out to Directorates as part of our Festival of Learning. The competencies are also included in the new Appraisal process for this year for colleagues to rate themselves on each of them; this will enable us to look at training need across these competencies and will inform future training

Festival of Learning: throughout summer and to support the ICB's First 100 Days, colleagues across the ICB have been reminded and encouraged to undertake learning and development through various offers of training including NHS Elect

Impact (for staff & residents): Delivering the LBB programme and increasing the number of Alumni to this programme we grow our leaders capacity to lead across organisational and professional boundaries.

Next Steps: ICB competencies roadshow as part of festival of learning. In September we are launching the Bedfordshire Peer Learning Network

Primary Care Training Hub: Exec Lead: susi.clarke@nhs.net

Key Achievements:

Student Pharmacist Summer placement programme – Hugely successful across BLMK with several of the student pharmacists offered jobs in practice when qualify. Practices keen to be involved in next year's programme.

Strategic Advanced Clinical Practitioner appointed to support ACPs in Primary Care and set up ACP forum

Number of First Contact Practitioner Supervisors increased to 15 to support FCP roles in Primary Care

GP mentors currently supporting 20 mentees, further cohorts of Mentor training rolling out from September 22

Lantum contract extended until Feb 23 – currently 45 practices signed up

Funding received to establish PCN training teams to expand clinical & non-clinical placements & embed training & education

Funding received to establish Community Pharmacy Integration projects with 2 PCNs & development of Community Pharmacist Leadership programme

Impact (for staff & residents):

Attracting local residents to undertake placements / apprenticeships within BLMK Primary Care

Supporting wellbeing and resilience has direct effect on patient care

Increasing workforce supply to grow future workforce & retaining existing experienced staff

Next Steps:

Further support to PCN development – leadership development, organisational development & culture change

Refreshing the PC Workforce strategy to encompass Fuller Review recommendations

Health and Wellbeing, Equality, Diversity & Inclusion

Exec Lead:

This Sub group is currently under development. Our first meeting will be in October any who have an interest or a role relating to Health and wellbeing and/or E,D&I. Id you are interested please contact emily.carter2@nhs.net

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
8. Milton Keynes (MK) Together Health & Care Partnership – "MK Deal" update

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☐	Ways of working ☐	Estates ☐
Communications ☐	Finance ☐	Operational and Clinical Excellence ☐	Governance and Compliance ☐
Other ☐ (please advise):			

What are the members being asked to do?		
Approve ☒	Note ☐	Discuss ☐

Report Author	David Stout, Development Director, Milton Keynes Health & Care Partnership Maria Wogan, Chief of System Assurance and Corporate Services, BLMK Integrated Care Board
Date to which the information this report is based on was accurate	23 September 2022
Senior Responsible Owner	Michael Bracey, Chief Executive, Milton Keynes Council

	Felicity Cox, Chief Executive, BLMK Integrated Care Board

Executive summary
This paper sets out the proposed MK 'Deal' It proposes the roles and responsibilities to be taken on by the Milton Keynes Health & Care Partnership (MKHCP) on behalf of the ICB in 2022/23 and the resources which the ICB will make available to support delivery of those responsibilities.
What are the available options?
Main options are: 1. To agree the proposed MK 'deal' at the ICB board 30 September 2022 2. To delay the finalisation of the MK 'deal' 3. To develop an alternative approach to place based working in MK 4. To not progress place based working in MK at this time
Recommendation/s
The members are asked to **agree** the following recommendation: • Agree the proposed MK Deal' and the next steps set out in the paper.
Key Risks and Issues
Key risks - Delay in agreeing the MK 'deal' leads to loss of commitment to place based working

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒
Not at this stage.		

Are there any financial implications or other resourcing implications?
Detailed financial implications to be assessed and agreed at the ICB Board meeting on 30 September 2022 – see section 8 of the report
How will / does this work help to address the Green Plan Commitments? Click to view Green Plan
This is not applicable in this circumstance.
How will / does this work help to address inequalities?
The proposed priorities for improvement will all address inequalities in MK
The following individuals were consulted and involved in the development of this report:
Milton Keynes Joint Leadership Team (JLT) BLMK ICB Executive Team
Next steps:
Set out in section 13 of the report

Appendices
Appendix 1 – proposed MK ‘Deal’

Milton Keynes (MK) Health and Care Partnership – MK ‘deal’

1. Introduction

1.1 The BLMK Integrated Care Board (ICB) board approved the following recommendations at its meeting on 29 July 2022:

a. That the Integrated Care Board recognise and endorse the new place-based partnership structures that have been put in place in Milton Keynes.
b. That the Integrated Care Board tasks the Integrated Care Board executive team to work out what roles and responsibilities can be delegated to the Milton Keynes place-based partnership, in line with the improvement areas identified and bring back details for consideration by the Integrated Care Board at its next meeting on 30 September 2022, including timeframes for maturity.

1.2 This paper sets out the proposed MK ‘Deal’ It proposes the roles and responsibilities to be taken on by the Milton Keynes Health & Care Partnership (MKHCP) on behalf of the ICB in 2022/23 and the resources which the ICB will make available to support delivery of those responsibilities.

2. Recommendations

2.1 That the ICB agrees the proposed MK Deal’ and the next steps set out in the paper.

3. Development of the proposed MK ‘Deal’

3.1 Following the discussion at the ICB Board meeting on 29 July 2022, the ICB Executive Team have worked with colleagues in MK to set out the roles and responsibilities which could be taken on by MKHCP on behalf of the in the priority areas which have been identified.

3.2 The ICB staffing resources currently associated with these responsibilities were identified by the ICB Executive Team as part of a wider exercise to map resources to place and the Bedfordshire Care Alliance to ensure equity of approach.

3.3 An initial draft of the proposed MK ‘Deal’ was reviewed at the ICB Executive Team meeting on 7th September 2022 and at the MK JLT on 8th September 2022. The final version was reviewed for submission to the ICB board at the ICB Executive Team meeting on 21st September 2022 and at the MK JLT on 22nd September 2022.

4. The proposed MK ‘Deal’

4.1 The proposed MK ‘Deal’ is attached as Appendix One. It sets out:

- The purpose of the MK ‘Deal’ as endorsed by the ICB board on 29 July 2022
- The principles for developing the agreement
- The governance and oversight arrangements
- The overall responsibilities being taken on by MKHCP on behalf of the ICB under the ‘deal’
- The financial responsibilities
- What we are trying to achieve and specific responsibilities being taken on in each of the four agreed priority areas
- The approach to resources (people) within the ICB supporting the ‘deal’
- The initial resourcing proposal

5. Next Steps

5.1 The attached proposed MK ‘Deal’ paper sets out the proposed next steps in section 13:

- agreement of this MK 'Deal’ at the ICB board meeting on 30 September 2022 and at the MK Health & Care Partnership Board meeting on 12 October 2022
- agreement of key performance metrics and reporting requirements by end October 2022
- establishment by MK JLT of governance arrangements for developing detailed work programmes for delivery of the agreed responsibilities by end October 2022
- finalising the initial resource plan and development of the MK Improvement Action Team initial ways of working by end October
- MK & ICB Finance Directors meet to finalise the detail of the financial arrangements by the end of October 2022
- ‘go live’ decision on each workstream in the ‘deal’ by end October 2022
- development of initial delivery plans including resources for delivery by end December 2022
- quarterly reviews of progress from December 2022 with an update report to the ICB in January 2023
- agreement of any changes to the MK ’Deal’ by end March 2023, including potential for formal delegation of ICB responsibilities with associated resources
- delivering the longer term resource plan for the MK Improvement Action Team by end September 2023

End of report

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

MK Together | Health and Care Partnership

Milton Keynes (MK) Together Health and Care Partnership – MK 'deal'

1. Introduction

1.1 The Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board (ICB) at its board meeting on 29 July 2022 recognised and endorsed and endorsed the new place-based partnership structures that have been put in place in Milton Keynes (MK).

1.2 The ICB also tasked its executive team to work with MK partners to set out what roles and responsibilities can be taken on by the MK Health & Care Partnership (MKHCP) on behalf of the ICB, in line with the improvement areas identified and bring back proposals for consideration by the ICB at its next meeting on 30 September 2022, including a timetable for development of maturity of the partnership.

1.3 This paper seeks to set out the agreement between ICB and MKHCP through the MK 'deal'. It sets out the arrangements and responsibilities that will be put in place to provide assurance to both parties that the range of responsibilities being taken on by MKHCP are appropriate, accountability is clear, and resources are aligned appropriately. It also sets out proposed next steps.

2. The MK 'deal'

2.1 The MK 'deal' is a formal agreement between the MKHCP and the BLMK ICB with three parts:

- It formalises the commitment of the main local NHS partners in MK and the MK Council to work more closely together (including forming and sustaining a Joint Leadership Team).
- It focuses on areas which the local area wants to improve, as endorsed by the MK Health and Care Partnership and fully in line with the BLMK Health & Care Partnership's strategic priorities and informed by both evidence of population health needs and a pragmatic assessment that the areas are ones where progress can be made.
- It sets out the remit and resources that the ICB agrees to pass to the local partners in the MKHCP (both formal and informal) to both help with the delivery of the specifically agreed improvement areas and to the general effective running of the local health and care system.

2.2 The objective of the 'deal' is to drive improvements in population health and improvements in the quality and efficiency of the health and care services provided to local people through the development of stronger local partnerships. The MK 'deal' aims to provide the foundation for both the local delivery of the strategic objectives of the BLMK integrated population health strategy and the opportunity for BLMK ICS to become a national leader in the establishment of inclusive and impactful place-based working.

2.3 The content of the MK 'deal' will iterate over time as the partnership matures, but initially focuses on four initial improvement areas agreed by MKHCP at its meeting on 1 June 2022.

3. Principles for developing the agreement

3.1 The establishment of the MK 'Deal' aligns with the principles underpinning the ICB Target Operating Model agreed by the BLMK ICS Steering Group

- A thin assurance and governance function that is accountable for the delivery of the ICB plans and outcomes via the system delivery structures (Place and Alliance) developed as set out above
- Only retains the budget for running the board, partnership, strategic commissioning, together with its statutory functions and, assurance and performance function. All other budgets/contracts are delegated over time
- As well as holding collaboratives and Places to account, the ICB should also hold the strategic commissioning function that utilises population health data to ensure system services are well planned
- The ICB will need a strong data-driven reporting and assurance function that works across all areas measuring progress and working to mitigate risk
- If needed, the ICB will act as the arbiter of dispute between the system delivery structures when services are not successfully implemented and proposed outcomes are not realised, as well as signing off plans
- That until functions are formally delegated to the Alliances or Places, they (along with the budgets and contracts) will be retained within ICB
- Implementation of these new ways of working and delegation arrangements will require a comprehensive and sustained system-wide organisational development programme for our senior leaders, managers, and clinicians across the ICS to facilitate a cultural, strategic and operational change to build common understanding, new relationships and different ways of working.

3.2 The implementation of the MK 'Deal' will be guided by the principles previously agreed by the BLMK Integrated Care System Chief Executive Group as part of the Migration Framework:

- Decisions should be driven by the principle of subsidiarity with decisions taken as close to local communities as possible
- Activities should be undertaken at scale where there are demonstrable benefits in doing things once, or where co-ordination adds value
- Migration should be on the basis that it (the thing being migrated) will deliver clear benefits to population health, individual patient or service user outcomes, or improved value for money
- Migration must ensure functional knowledge is maintained/improved, so that patients and service users remain safe, have a good experience and that outcomes are improved.
- Partners at place should consider how they work as part of ICS governance to support decision-making at scale including liaising and making decisions with at scale provider collaboratives.
- The ICB can align and in time migrate functions and resources but cannot migrate accountability. Therefore, the system will need appropriate RACI (Responsible, Accountable, Consulted, and Informed) and risk management arrangements to manage in the new environment.
- We need to value people and their skills. We will ensure we retain and build our talent and harness their skills in the new system architecture. We need a minimal disruption approach to any changes, using functional changes of roles and focus rather than organisation restructures where we can. The ICB and other respective employers in this partnership will retain employment and responsibility for the members of staff aligned into place in line with NHS

England's policy. There will be clear line management and team development in place at 'place' to support the effectiveness of these teams and the experience at work of the aligned employees. Any clinical professionals will be supported to continue their CPD as required. All staff will have clear individual objectives, personal development plans and supervision of their work.

- We will apply an equality, diversity, and inclusion lens to all that we do both in the employment opportunities created within the MK improvement team and transformation in service delivery which the MK Deal will create
- The ICB will work with receiving entities to ensure clarity on the required outcomes of any migrated work
- Resources (including management support) will be adequate to deliver the migrated work and responsibilities and distributed via a fair, equitable and transparent process. All partners will be supporting and supplying adequate workforce at place to deliver the work.
- There will be a mutual open book relationship in terms of performance and finance
- All partners will work together to undertake the necessary organisational development to ensure joint understanding and commitment to the new culture and ways of working. Specifically, the matrix working approach will be defined, assessed and adjusted to support a productive and effective work experience for aligned staff. We will ensure that staff continue to feel valued, have a positive working experience, and are developed in order to full contribute to agreed priorities.

4 Governance and oversight

4.1 The Milton Keynes Joint Leadership Team (JLT) will establish appropriate governance arrangements for oversight of the functions being taken on by the MKHCP on behalf of the ICB. The JLT will be accountable to the MKHCP Board and the ICB for delivery of agreed objectives.

4.2 We will together develop a set of metrics that are relevant to these aims in order both to enable partners to track progress and achievement (and intervene where things are off track) and provide assurance to the ICB that the system is managing its demand. These largely exist but we should take a subset of the really important metrics in order to focus on what really matters and will include the experience of the staff working in this joint team.

4.3 Performance reporting will be transparent to all partners including through the relevant ICB structures including the ICS Performance & Delivery Group, on a monthly basis and the quarterly System Oversight & Assurance Group. This reporting will be proportionate to the level of resources and spending decisions being taken on by MKHCP.

5. Responsibilities being taken on by MKCHP on behalf of the ICB

5.1 In the agreed areas set out in the following sections of this document, MKHCP will take on the following responsibilities on behalf of the ICB:

- Providing health & care leadership for MK transformation programmes to support reducing unwarranted variation and health inequalities within MK
- Adoption of population health management approach in local prioritisation and decision-making
- Reporting on performance in achieving population health outcomes
- Setting local priorities and action plans to address inequalities
- Delivery of MK performance in line with system, regional and national requirements, and collaborative working to address any areas where performance improvement is required
- Delivery and performance tracking of functions and priorities for improvement taken on by MKHCP and reporting to ICB as required

- Establishment and management of MK governance arrangements to ensure effective assurance for the MKHCP
- Identification of material risks that impact the achievement of the MKHCP strategic objectives and management of the risks through implementing and monitoring mechanisms
- MK Health & Care Partnership to establish governance arrangements and decision-making processes to resolve disagreements at local level
- Agree a disputes resolution mechanism for any disputes between the ICB and MKHCP
- Partner employers remain responsible for the employment, including the wellbeing of their staff aligned into this work. All partners will regularly review the experience of the staff they employ who are aligned into this work.

5.2 Where MKHCP take on responsibilities on behalf of the ICB it is agreed that the MKHCP has 'permission to act' in the agreed areas with light touch oversight from the ICB based on the agreed performance metrics. However, if there are significant performance issues in these areas, the ICB reserves the right to intervene in a proportionate way as illustrated by the following scenario, which also illustrates the role the Regional team may play.

5.3 *Scenario: Milton Keynes has historically had good A&E performance relative to other places. However, for a period of several months there has been a marked and persistent deterioration in its relative A&E performance. This scenario has been chosen because resolving such an issue will involve the full system, with both pre-hospital and post-hospital patient pathways impacting on the performance, requiring actions from a variety of system partners. The ICB would lead the response, but the regional team would expect to be invited to key meetings where the issue was being addressed. An improvement plan would be put in place by MKHCP with the support of the ICB and would be shared for information with the regional team. Any direct contact with the MKHCP would happen in meetings led by the ICB. The ICB and regional team would offer improvement resource if appropriate and available, but MKHCP may choose to utilise its own improvement resource. There would be joint escalation plans in place in the event of performance not improving, which would be triggered by the system if appropriate. A single item assurance meeting may be called between the ICB and MKHCP (with regional input if required), where MKHCP will be able to clearly show that they understand the root causes of the problem and the actions required.*

6. Financial Responsibilities

6.1 The financial resources currently deployed by the ICB in the specified areas of responsibility being taken on by MKHCP will be set out in the 'deal' as clearly as possible within the constraints of the current financial reporting structures. MKHCP will be responsible for decisions to deploy these resources to best meet the needs of the population.

6.2 Where new financial allocations are received by the ICB during the year relevant to the agreed areas of responsibility being taken on by MKHCP, these will be made available to MKHCP on a fair shares or other agreed apportionment basis agreed through the BLMK system finance directors' group.

6.3 The ICB will remain accountable for the overall financial performance of the system and no new financial risk share with partners within MKHCP is proposed as part the 'deal' at this stage. However, the expectation is that passing responsibility to MKHCP in the specified areas will lead to more effective use of financial and other resources and all parties within MKHCP are fully committed to delivering best use of resources. This will be underpinned by an open book accounting approach and regular reporting by MKHCP to the ICB to ensure full transparency on financial performance in the areas of responsibility being taken on by MKHCP within the MK 'deal. As part of the next steps,

it is proposed that the Finance Directors meet to finalise the detail of the financial arrangements by the end of October.

7 Avoiding unnecessary hospital stays/Improving system flow

7.1 *What are we seeking to achieve?*

7.1.1 All parties recognise that large scale transformation of Urgent & Emergency Care services, if it is to be successful and sustained, must take place at sub-system level with providers working together to reshape demand, and the delivery of care.

7.1.2 The ICB will want to know and be assured that this is happening and that there are clear objectives guiding the changes being enacted in MK. Together we are seeking to transfer clear responsibility for system flow to the MKHCP with partners working together to:

- Deliver better outcomes, with local people able to live healthier independent lives
- Get people home as quickly as possible after a hospital or community bedded stay is completed, in order to maintain people's independence and minimise decompensation
- Reduce average lengths of stay in hospital and other bedded care removing barriers to early discharge, and focusing on reablement from the point of admission
- Better integrate discharge services to avoid duplication and maximising opportunities to resolve issues creating unnecessary admissions and attendances
- Reduce reliance on long term care caused by delay and decompensation
- Ensure people are seen in the right place for their condition, with attendances, conveyances and admissions to hospital reduced from currently projected levels by services
- Secure system capacity to support these aims
- Reduce overall system costs in relation to the provision of urgent and emergency care, in order that a) that MK and wider ICS are financially sustainable AND b) provide headroom for upstream investment in prevention and out of hospital care.
    - Review Better Care Fund schemes to ensure coherence with the aims of the MK Deal: value for money and effectiveness
    - Utilise S256 funding in a way that maintains discharge and flow in the short term, while the system transforms

7.1.3 The initial range of services within the scope of this agreement have been agreed by the ICB Executive Team and the MK JLT.

7.2 What responsibilities will the MK Health & Care Partnership take on behalf of the ICB?

7.2.1 It is proposed that the MKHCP takes on the following responsibilities in relation to Urgent & Emergency Care & Flow:

- Leading Health & Care Partnership-based transformation programmes to deliver both ICP & ICB-set priorities and locally designed changes
- identifying and deciding the services necessary to meet the needs of the population including design of new pathways, services and/or ways of working for all services within MK (other than specialist services see above) to best meet local needs within allocated resources, working with finance, contracting, primary care and quality colleagues to ensure this is done to provide high quality care at best value

7.2.2 Where functions and responsibilities are retained by the ICB, any decisions which impact on the responsibilities being taken on by the MKHCP will be taken with appropriate input from and engagement with partners within MKHCP on the principle of 'no decision about me without me'.

8. Children and young people's mental health

8.1 *What are we seeking to achieve?*

8.1.1 The system acknowledges that promoting children's emotional health and wellbeing and offering evidence-based interventions in a timely and accessible way is essential if children are to become resilient adults. It is also clear that there are groups of vulnerable children in MK e.g., looked after children who are at much greater risk of poor mental health and therefore require more targeted interventions.

8.1.2 Good mental health in children and young people helps build resilience, develop healthy relationships and lays the foundation for better mental and physical health and wellbeing throughout their whole lives. Early intervention is key for lifelong wellbeing: 75% of adult mental health issues are present by the age of 24.

8.1.3 The number of young people with a probable mental disorder increased between 2017 and 2021: in 6 to 16 year olds from one in nine (11.6%) to one in six (17.4%), and in 17 to 19 year olds from one in ten (10.1%) to one in six (17.4%).

- Using national prevalence data, the number of children and young people in MK expected to have a diagnosable mental health problem age 5-17
- Using local access data, the number of children and young people in BLMK accessing local services

8.1.4 Despite a 60% increase in funding for CAMHS in MK over the past five years the current budgeted workforce does not support the increase in demand for services. The system recognises that there is an urgent need to rebalance the system in line with national best practice so that our children and young people "Thrive" (http://implementingthrive.org/)

8.1.5 Children and young people's mental health is a partnership responsibility and as such the MK Health and Care Partnership will want to see improvements in prevention and early help and in care of complex and vulnerable young people:

8.1.6 Prevention and early help

- A full needs assessment based on the recently published BLMK Insights Pack from East of England Regional Team.
- A high-level mapping of current MK provision for getting advice, support and help, to include funding sources.
- Market development exercise to understand and develop capacity within the VCSE.
- Business case to address gaps identified in having a systemwide provision of getting advice, support and early help.
- Equality Impact Assessment to ensure the business case addresses the needs of vulnerable children.
- A clear and transparent approach to coproducing this with children and young people and parents and carers.
- Secure new provision using the most appropriate framework which could include local grants, contract extensions and/or procurement.

8.1.7 Complex and vulnerable care

- Immediate work to scope exactly which pathways the team will be responsible for and the interface with the workstream on managing complex needs.
- Scope the regional and BLMK wide work that already supports this priority and clarify MK interface (e.g Provider Collaborative).
- Identify areas where outcomes and effectiveness can be improved for children and young people and get best use of system resources.

8.2 *What responsibilities will the MK Health & Care Partnership take on behalf of the ICB?*

8.2.1 It is proposed that the MKHCP takes on the following responsibilities in relation to children and young people's mental health:

- Leading Health & Care Partnership-based work plans to improve outcomes for children and young people's mental health.
- Interfacing with the ICB Mental Health Transformation Programme to ensure join up for key deliverables and recovery plans.
- Ensuring that plans will address inequalities across MK.
- Providing assurance as required to NHSE
- identifying and deciding the services necessary to meet the needs of the population including design of new pathways, services, working with finance, contracting, primary care and quality colleagues to ensure this is done to provide high quality care at best value.

9. Tackling obesity

9.1 *What are we seeking to achieve?*

9.1.1 All parties recognise that obesity services with supporting networks are best developed and managed at a local place level. The ICB will want to know and be assured that any changes to ICB-led initiatives have clear objectives guiding the alterations being enacted in MKHCP.

9.1.2 Together, we are seeking to achieve the following:

- Clear and accessible support for individuals in MK who want to lose weight, with a BLMK system responsibility to ensure an equitable service offer in order to address inequalities, particularly for people at higher risk due to socio-economic circumstances and physical and mental health conditions that make it harder to maintain a healthy weight;
- Delivery of the national digital weight management and diabetes prevention programme offers are optimised within the local system, alongside the wider support primary care can provide including referral into Tier 3 and 4 services; Effective and appropriate use is made of community voluntary and social enterprise capacity
- Increased access to healthy food in MK, including while using health services;
- Improvements to the environment in MK to make it easier for people to maintain a healthy weight
- Over time. a reduction in the proportion of people aged over 18 with BMIs over 25;
- Over time. a reduction in the proportion of Reception and Year 6 children who are overweight or obese.

9.2 What responsibilities will the MK Health & Care Partnership take on behalf of the ICB?

9.2.1 Specifically in obesity management and maintenance of a healthy weight, the following services are currently commissioned or have local oversight/accountability through the ICB and could be taken on by the MK Health & Care Partnership:

- Oversight and accountability for the delivery of the national digital weight management offer and national diabetes prevention programme via primary care, to NHSE
- Accountability to agree and monitor weight management DES with Primary Medical Services
- identifying and deciding the services necessary to meet the needs of the population including design of tier 3 and tier 4 weight management services

9.2.2 In addition, the ICB has a strategic and cross-cutting role in relation to healthy weight as part of wider discussions around prevention and health inequalities. While it will not be possible to fully separate MK from these discussions, ownership of any implications in terms of service delivery or service design in MK could be formally passed to the Health & Care Partnership.

10. Managing complex needs

10.1 *What are we seeking to achieve?*

10.1.1 All parties recognise that to deliver improved outcomes for people of all ages who have complex needs we need a well-resourced, professional, and consistently applied local pro-active model of assessment, planning and case management. We will need to agree a definition of complex needs to identify the opportunities that a different, integrated approach could deliver.

10.1.2 To deliver improved outcomes of people of all ages who have complex needs we need to transform referral pathways, care and support planning and case management, so that health and social care professionals work together to apply proactive and simplified processes and procedures. The ICB will want to know and be assured that this is happening and that there are clear objectives guiding the changes being enacted in MKHCP.

10.1.3 Initial discussions have agreed that we could start by focussing on people with a learning disability and /or autism and/or physical complexities between the ages of fourteen and twenty-five years. The benefit of this focus is that we know that the management of learning disabilities is an existing priority for the ICB, and we also have evidence that a pro-active model of assessment, planning and case management for people between 14 and 25 years is likely to reap benefits in terms of reducing emergency placements that are often outside of Milton Keynes at a high cost.

10.1.4 Together, we are seeking to initially scope the systems for the assessment, planning and case management of people with complex needs, identifying the opportunities to develop an integrated system that reduces delays and utilise the skills across the system to get the right care and support in place that is then regularly reviewed to ensure that needs are met and outcomes are achieved. Actions to achieve these objectives include:

- Agree a shared definition of complex needs to identify potential opportunities for integrated systems.
- Conduct a high-level review of the ways the budget is spent with a view to identifying medium to long term efficiencies in any placement and/or support costs, agreeing to stop doing things that do not have evidence of positive impact.
- Agree with the ICB how funding for complex needs including CHC decision-making and funding will be managed in Milton Keynes focussed on delivering a robust, simplified approach.
- Develop proposals to achieve a jointly coordinated approach to early identification and support, management, and review of people 14-25 years with complex needs. To include people funded by social care, health or jointly between health and social care.

- Reduce the use of placements outside of Milton Keynes (out of area placements) by using the data and intelligence we have across the system to identify and decide the services necessary to meet the needs of the population including support 'closer to home'.
- Introduce an integrated case management approach for children, young people and adults, 14-25 years who have complex needs.
- Provide headroom for upstream investment in prevention and early intervention. For example, reducing waits for autism and attention deficit hyperactivity disorder (ADHD) followed by pro-active intervention where these are needed.
- Explore the opportunities for market development for complex needs provision within Milton Keynes (or a wider footprint for highly specialist care and support)
- Ensure that links to the MK Deal work for Child and Adolescent Mental Health Services are maintained to reduce duplication of effort and capitalise on potential opportunities.
- Secure system capacity to support these aims

10.2 *What responsibilities will the MK Health & Care Partnership take on behalf of the ICB?*

10.2.1 It is proposed that the MKHCP takes on the following responsibilities in relation to the management of complex needs:

- Leading Health & Care Partnership-based transformation programmes to deliver both ICP & ICB-set priorities and locally designed changes
- identifying and deciding the services necessary to meet the needs of the population including design of new pathways, services and/or ways of working for services for CYP and adults 14-25 years within MK (other than specialist services see above) to best meet local needs within allocated resources, working with finance, continuing healthcare and complex care, children, and adults social care, contracting, primary care and quality colleagues to ensure this is done to provide high quality care at best value.

11. Resources (People) - approach

11.1 ICB staff working directly on the functions and responsibilities being taken on by MKHCP through the MK 'deal' will be aligned to MKHCP and become members of the MK Improvement Action Team. They will report to the Head of the MK Improvement Action Team who is accountable to the chair of the MK Joint Leadership Team with 'dotted line' accountability to the MK Place Link Director in the ICB. Staff will remain employees of the ICB.

11.2 For the aligned ICB staff and colleagues from MK partners organisations who are working together to deliver the MK 'deal', being part of a high performing team that delivers faster improvements of services is essential. The ICB and MKHCP will invest in best practice approaches to developing strong collaborative ways of working across organisational boundaries to develop the operating model for the initial MK 'deal' which will provide a strong platform for extending it in the future piece of work

11.3 Where the ICB employs staff who are completely focussed on work captured within the MK Deal, we will work with those staff to support them moving into the MK Action Planning Team. A transparent framework will be created in line with fair HR processes that reflect the commitments made to all staff in the NHS People Plan. Identification of the posts that offer greatest alignment has already begun, and will move at pace once this paper is agreed. Staff within scope will be supported in embracing this change and the opportunities it creates. The ICB People directorate will take responsibility for consultation with affected staff and the Staff Partnership Forum. Where there is scarce resource and expertise that is required in all parts of the BLMK system, the ICB will support

our partners in agreeing equitable access to that resource. ICB staff whose work and focus is realigned to support the MK Deal will continue to enjoy the benefits of working for the ICB and the forward looking working practices such as hybrid working.

11.4 Any future changes to employment arrangements could only take place if formal delegation of Responsibilities were to be agreed and would be subject to full consultation. A full assessment, based on employment policies in the employing organisations, will take place to ensure that any future employment models respect and treat all employees fairly. NHS England's policy on aligning, embedding and transferring staff will be used to review any NHS staff's transfer into future operating models from any of the respective NHS organisations in the partnership. Local government employment policies will be employed in respect of any local government employees in the partnership. This will be done in partnership with staff side colleagues in all the respective organisations in the partnership.

12. Initial resourcing proposals

12.1 Already the ICB has put in place a Place Linked Director for MK who it has been agreed will join the MK JLT and will ensure that arrangements for support from the ICB are working effectively. In addition, the ICB has seconded a member of staff into the role of Head of the MK Improvement Action Team in September 2022.

12.2 The ICB Executive Team have reviewed ICB existing staffing resources to identify the current capacity which supports the priority areas within the MK 'Deal' as a starting point for supporting MKHCP to deliver improvement in these areas. Based on this analysis the current ICB the following capacity from the ICB commissioning team would be aligned to support the MK 'Deal':

- *Avoiding unnecessary hospital stays/system flow* - 3.4 wte including 1.0wte (band 8a) post which can be aligned entirely to the MK Improvement Action Team
- *Children & Young People Mental Health* – 0.2 wte
- *Managing Complex Needs* - 0.1 wte in children's and 0.3 wte in adults
- *Tackling Obesity* – there is no identifiable existing capacity in this area

12.3 While this fairly reflects existing capacity, given the scale of responsibility being taken on by MKHCP it is recognised that this is not sufficient resource to enable MKHCP to drive improvement. Over the next 12 months the ICB plans to refocus its resources to support place based working and provider collaboratives, recognising that we are in a year of transition we are proposing to use non-recurrent funding to initiate the 'deal'.

12.4 Therefore it is proposed that we supplement the existing capacity we have identified for support for the MK 'Deal' as follows:

- *Avoiding unnecessary hospital stays/system flow* – recognising the scale of the responsibilities being taken on by MKHCP it is proposed that we fund additional capacity through use of the S256 funding which was agreed for 2022/23

- *Children & Young People Mental Health* – deployment of consultancy support funding from NHS East of England in relation to CAMHS transformation into MK (details TBC)

- *Managing Complex Needs* – funding of a Learning Disabilities Programme Director post funded from projected underspends in the pooled LD budget to provide additional capacity to drive transformation in this area

- *Tackling Obesity* – deployment of the population health budget which was transferred to MK by the ICB in 2022/23 to establish additional capacity to drive transformation this area

12.5 In addition to the resources directly supporting work areas in the MK 'Deal', there are other staff in the ICB who are aligned to wider work in MK and whose work will contribute to transformation and operational management of the areas in the MK 'Deal'. This includes corporate services such as finance, contract management, procurement and communications and other more front-line facing teams such as the Primary Care team who oversee the commissioning and performance management of the national primary care contracts and supports the primary care contribution to the MK Deal priorities. The primary care team is structured to be sensitive and responsive to place working in an agile manner with matrix working and some hybrid roles to provide expert areas of Primary Care commissioning. Such wider ICB capacity aligned to MK includes but is not limited to:

- Primary Care Team – circa 6 wte
- Medicines Optimisation Team – circa 8 wte
- Quality Team – circa 8 wte

12.6 During this year of transition, ICB colleagues in these roles will support the work included in the MK Deal and other ICB responsibilities in MK and these colleagues will be included in developing the way the MK Improvement Action Team works. The ICB will work with MK partners to develop an effective way of working that enables MK facing colleagues to directly support the priorities of the MK Deal and place. The ICB Place Linked Director for MK will have a role in working with fellow ICB Executives to allocate sufficient resource to support delivery of the MK 'deal'.

13. Next Steps

13.1 The key next steps are:

- agreement of this MK 'Deal' at the ICB board meeting on 30 September 2022 and at the MK Health & Care Partnership Board meeting on 12 October 2022
- agreement of key performance metrics and reporting requirements by end October 2022
- establishment by MK JLT of governance arrangements for developing detailed work programmes for delivery of the agreed responsibilities by end October 2022
- MK & ICB Finance Directors meet to finalise the detail of the financial arrangements by the end of October 2022
- finalising the initial resource plan and development of the MK Improvement Action Team initial ways of working by end October
- 'go live' decision on each workstream in the 'deal' by end October 2022
- development of initial delivery plans including resources for delivery by end December 2022
- quarterly reviews of progress from December 2022 with an update report to the ICB in January 2023
- agreement of any changes to the MK 'Deal' by end March 2023, including potential for formal delegation of ICB responsibilities with associated resources
- delivering the longer term resource plan for the MK Improvement Action Team by end September 2023

End of report

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
9. Digital Strategy

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☒	Workforce ☒	Ways of working ☒	Estates ☒
Communications ☒	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☒
Other ☐ (please advise):			

What are the members being asked to do?		
Approve ☒	Note ☐	Discuss ☐

Report Author	**Mark Thomas** - Chief Digital and Information Officer, Bedfordshire, Luton and Milton Keynes Integrated Care System **Clare Steward** - Programme Director, Digital Delivery, Bedfordshire, Luton and Milton Keynes Integrated Care System
Date to which the information this report is based on was accurate	15/09/2022

Senior Responsible Owner	Mark Thomas, Chief Digital and Information Officer BLMK ICB

Executive summary

This attached digital strategy is the culmination of several months collaboration and co-design with all the partner organisations to develop a digital vision for BLMK to deliver over the next three years which all of the partner organisations have agreed.

Post pandemic the digital service delivery has to support transformation in how residents receive and participate in their health and care. All the partners have developed this digital vision for the future at the same time as delivering the What Good Looks Like (WGLL) national framework for digital maturity which is being utilised to accelerate digital and data transformation across all ICB's in England.

BLMK success criteria are themed through all the priorities of the strategy and the development plans which focuses on improving population health outcomes, improving efficiency, experience, and safety to transform health and care. BLMK investment plan for 2022/23 has a total funding of circa £11M

We now seek formal agreement from the ICB Partnership Board for System adoption and delivery.

What are the available options?

Not applicable

Recommendation/s

The members are asked the following:

1) **Note** the contents of this paper
2) **Approve** the content of the ICS Digital Strategy
3) **Support** the What Good Looks Like as our 22-23 delivery plan

Key Risks and Issues

1. Perception that the strategy has failed to include an item of strategic importance
2. Lack of resource available to the system to take forward the ambition set out within the strategy to delivery
3. Note that the process for production of the strategy and the document was chosen deliberately to minimise these risks.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

Are there any financial implications or other resourcing implications?

The findings of the ICS Digital Strategy have been aligned to the drafting of the ICS One Year Digital Transformation Plan
The exception is the single data repository which will require new funding to support the programme team, the proposal will progress through the digital governance approval process in due course,

How will / does this work help to address the Green Plan Commitments? Click to view Green Plan
Use of digital supports all five aims of the Green plan from reduction of travel, ensuring our suppliers work towards carbon neutral (cloud computing), reduction of travel for our residents and through smart working for our staff too.
How will / does this work help to address inequalities?
The following individuals were consulted and involved in the development of this report:
The nature of the ambition seeks to ensure that Digital Strategy is aligned to support those most in need of health and care services across the ICS enabling resources to be better targeted going forwards. While we adopt digital first it is not a digital only and we work with our residents to co-design non-digital access to service.
Next steps:
1. Agree any further points identified by this board to be incorporated into the strategy. 2. Consider whether an additional simplified version would be appropriate for public consumption.
Appendices
Appendix A - BLMK ICS Digital Strategy Appendix B – BLMK What Good Looks Like report.

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

Digital Strategy

2022-2025

Working Draft, Version 1.13, not for wider distribution

Foreword

This document sets out the digital strategy for the Bedfordshire, Luton and Milton Keynes Health and Care Partnership for 2022-2025.

It has been produced with system partners, setting out how digital technology can support us to deliver the best outcomes for our residents, and support our teams to work effectively by making the best use of technology.

This strategy builds on the local and national strategies and standards, and considerable success that our system partners have already delivered through the innovative use of digital tools and services, not least in the face of the pandemic.

We have been working together with our system partners since 2018 and have established the strong foundations required for a successful partnership across BLMK. This supports the governance mechanisms to oversee and monitor the implementation of this strategy and the associated digital transformation board delivery plans.

The BLMK system is, at its heart, all about orienting services to enable everyone in our towns, villages and communities to live longer, healthier lives. This strategy focuses on how data and digital technologies can enhance the resident's ability to participate in all elements of their care and data.

Our **'digital-first, rather than digital-only'** approach ensures that we remain resident-focused, regardless of their digital skills.

We are excited about the potential for data and digital to drive improved outcomes and better experiences for residents and teams, and we look forward to working with system partners to make this strategy a reality.

Mark Thomas
Chief Digital and Information Officer
Bedfordshire, Luton and Milton Keynes Integrated Care System

You can find further information at: **https://blmkhealthandcarepartnership.org**

Why this digital strategy matters

Dr Sarah Whiteman
Chief Medical Officer

"Delivering better, more efficient care that improves outcomes for people is the reason we (the ICS) are here. In a modern world constrained by resources and delivered by a health and care workforce that is under increasing pressure we have to be more innovative. Key to our approach is our use of digital technology and that is the reason, as the Chief Medical Director for the Bedfordshire Luton and Milton Keynes Health and Care Partnership I am totally committed to our digital strategy as part our approach to care. We are keen to develop this further in collaboration with others so if you have a good idea let's hear it! Contact us – blmkicb.contactus@nhs.net

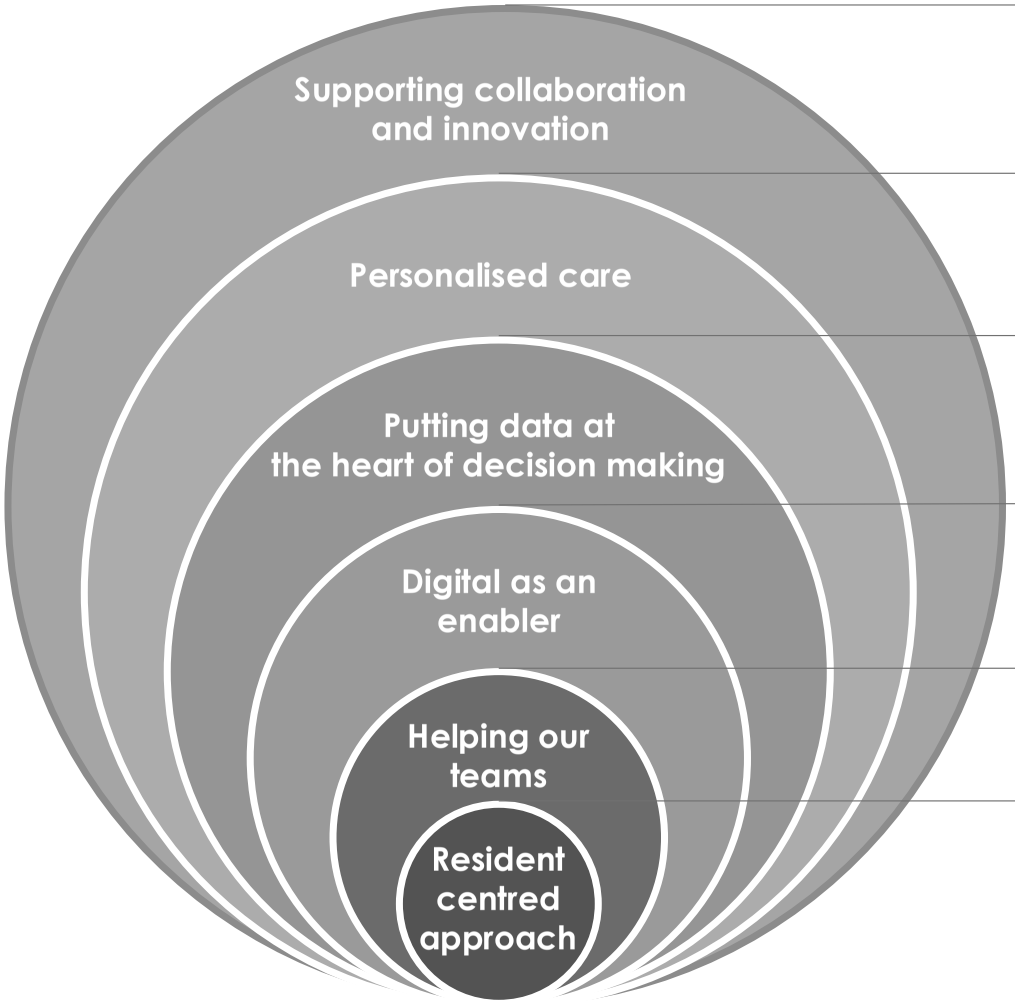
Julie Ogley –
Director of Social Care, Health and Housing,
Central Bedfordshire Council

"Digital services and digital inclusion are key enablers for local authorities to support residents to participate in good quality accessible advice and information about their treatment and care. It is important that the ambitions set out within the digital strategy enable us to join up our service provision across our health, care, voluntary and community services providers. To achieve this, we need our teams to have the latest technology advances available to them to provide more timely and effective care to our residents"

Dr Paul Singer
Chief Clinical Information Officer

"Our local residents rightly expect the best and most effective personal health and care services. We want to provide that high quality service from conception through to old age which requires the best use of every facility we have available. Digital tools give us the ability to make it easier to obtain care when you need it, provide that care closer to home and support self care. By sharing records where appropriate across the health and care sector we can give that personal service and by using the data in those records we can better plan effective and efficient services supporting residents and enabling care givers to do their jobs more easily.

This digital strategy provides a plan for using technology to support health and care at home or hospital settings both for those able to access services by digital means and for those who find it difficult so that together we can deliver the best care across BLMK.



6
- Evaluating & implementing emerging technologies
- Work with partners to evaluate new models of care
- Sharing what works and learning from others
- Effective governance structures

5
- Care closer to home
- Virtual wards
- Tailored services
- Enable precision medicine
- Remote care and connected devices

4
- Single Shared Care Record
- Improve Data quality
- Drive public & population health
- Improve Data availability
- Data-driven decisions
- Adopt a digital ethics charter

3
- Moving to Cloud-based services
- Improved data flow and connectivity
- Improve Systems use by consolidation
- Cyber security
- Integrate NHS App

2
- Supporting our teams with easy-to-use digital solutions
- Helping our health and care teams to help our residents

1
- Digital-first, rather than digital-only
- Building digital skills

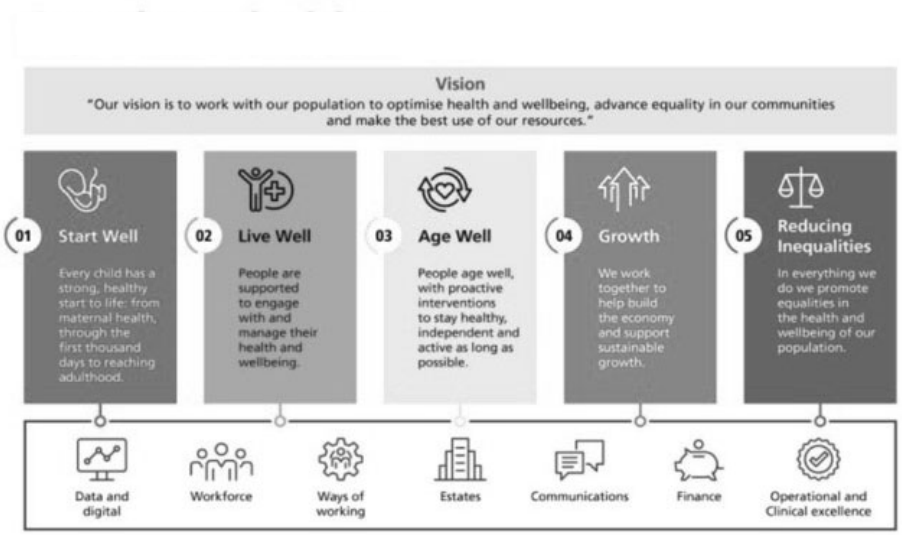
Executive summary

The BLMK ICS mission underpins this Digital Strategy…

"To work with our population to improve health and wellbeing, advance equality in our communities and make the best use of resources." We aim to increase the number of years people spend in good health and reduce the gap between the healthiest and least healthy in our community."

Supporting BLMK system priorities:

The BLMK ICS has identified its priorities and recognised "Data and Digital" as one of the key enabling functions that will support the ICS's Vision and Priorities.



How we created this strategy:

We have developed this Digital Strategy through interviewing numerous stakeholders across all BLMK partners, ensuring that we have considered as many views as possible. We combined those views to create the digital vision for integrated health and social care services across BLMK.

What residents told us:

Through contact with Healthwatch, we have taken the time to listen carefully to what our residents say. We understand that Digital technologies are a key part of meeting residents' interaction with health and care. They want better access to and visibility of our services and their records as well as easier ways for them to engage with their health and care professionals.

The 5 key themes in this ICS Digital Strategy:

This Digital strategy is organised around five key themes which are each explored in more detail in this document:

- **A resident first approach:** Ensuring we place the needs of our residents at the heart of our strategy.
- **Digital as an enabler:** Using digital to provide better care across our ICS.
- **Putting Data at the heart of decision making:** Using our data ethically and securely to make better decisions.
- **Personalised Care:** Discovering and implementing new ways of bringing care closer to our residents
- **Supporting Collaboration and Innovation:** Working together as a partnership to continually improve the health and care we provide.

Building on existing foundations

Our digital strategy builds upon our well-established data strategy alongside national standards and policy frameworks. We are building momentum in thinking and acting digitally, delivering better experiences for residents through practical digital service improvements.

BLMK data strategy:

Data is a key component of this Digital Strategy. We have deliberately aligned this Digital Strategy to our Data Strategy, which was co-produced and published in 2021 and is available here: https://blmkhealthandcarepartnership.org/our-priorities/data-and-digital/) As the Digital Strategy evolves in the coming years, we will ensure that the data strategy alignment remains intact thereby preserving the ability for data and digital technologies to meet the needs of our residents and partners.

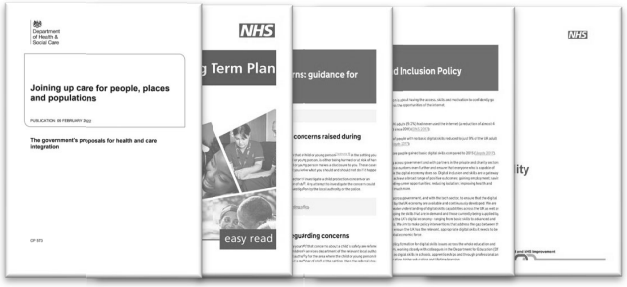
Building on existing standards:

This strategy relies on the careful and consistent adoption of agreed information and technology standards. These standards will improve the implementation of technologies and reduce whole system costs. We will work towards recognised common standards in healthcare and support our social care teams in adopting emerging guidance around social care data standards. Examples of standards are common coding and naming conventions for Medicine such as SNOMED CT, and interoperability through 'Fast Healthcare Interoperability Resources' (FHIR) and HL7.

National policy and engagement

The ICS exists within a national and regional context and we have deliberately aligned our strategy with existing national digital strategies, policies and guidelines. We will incorporate any further guidance as it is developed:

- NHS Long Term Plan
- Data Saves Lives
- Joining up care for People, Places and Populations
- What Good Looks Like
- The Future of Healthcare
- Scalable Approach to Vulnerability via Interoperability
- Ofsted Safeguarding Policy
- Equality Act 2010
- Digital Skills and Inclusion Policy
- Social Mobility Policy
- People at the Heart of Care
- Confidentiality Policy for Health and Social Care



A resident first approach

Not a digital-only service

We are adopting a **'digital-first, rather than digital-only'** approach to how we deliver care. This will ensure that everyone has a choice in how they interact and participate in managing their care journey. We will co-design new services with our partners and residents, to ensure services will meet the needs and expectations of the people who are using them. This includes ensuring that services are culturally appropriate and accessible. We will introduce different ways for our residents to communicate with care providers, so they can jointly agree on services that are best for them. The adoption of relevant multi-channel approaches will help improve access to services thereby bridging the digital divide.

Working beyond our geographical boundaries

While our residents will have much of their health and care needs met within the boundaries of BLMK, for some specialised services we will need to work with health and care partners in other parts of the country. We will work to ensure seamless connections with these wider partners. This will ensure that our residents have access to the best possible care wherever they need it.

Examples across our ICS

Initiative: Milton Keynes MyCare patient portal

Description: We implemented a Hospital Patient Portal called MyCare where patients can submit personal contributions and become more involved in the management of their care. The next phase is to enable secure 2-way dialogue between patient and clinician that remains part of patients' medical records allowing results and self-monitoring.

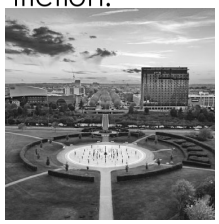
We're doing this to improve the lives of BLMK residents

Giving residents easier access to their information, tailoring digital solutions around their capabilities and enabling seamless care through shared information - even when 'off patch' - will improve residents' lives in ways that are important to them.

With our communities, we are developing digital guiding principles to ensure that digital services are easy to use, multi-lingual and easy to understand. Our residents will be able to easily access their health and care data so that they can actively contribute to their health and wellbeing. Residents will have the ability to nominate carers and family members to access their data in a controlled and secure way to support their care. This will provide greater transparency of health and care information relating to appointments, health conditions, care plans, choices and preferences.

Helping our teams and partners to help our residents

When putting residents first, we need to equip and enable our teams and partners with tools that enable them to work more effectively and strengthen the partnership between people and technology. We will be providing services for teams that are easy to use, valuable and impactful. We want digital devices to help make health and care both safer and easier and reduce digital friction.




A resident first approach

What residents have told us about their experience of care

"I'd prefer to have a text message or an e-mail to confirm my appointment. I don't want to have to wait for a letter in the post."

"My parents aren't comfortable engaging with technology. We'd like face-to-face to always remain an option for them."

"Getting access to the internet is expensive and I can't afford it. I don't want this to impact me accessing the health and care services I need."

"Voluntary and community groups provide support to me directly. I'd like them to have a conversation with me about the services they offer, to help me get online and stay online."

Our Digital Strategy will shape improving care capabilities

What care will feel like in 2025 for BLMK residents

"It's helpful that all the visits with people looking after my health and care are shared with my GP and each other. They all know my journey and now I don't have to repeat my story. I feel like I'm being treated in a more personal way because of this."

"When I don't need to see someone providing my care in person, I have an app that I can use to see them instead. I live in a care home so being able to use my app to keep in touch with my family is wonderful."

"Everything I need to help me manage my and my family's health and care online is easy to get to, easy to read and I can get it in my own language too."

"I've learned a lot about when I might need to see someone face-to-face or online and feel better making that decision because both are as easy to access and as good as each other. "

Digital as an Enabler

Care services are transforming at an amazing rate as new approaches to technology are embraced. Throughout the pandemic we saw new, technology-enabled ways of collaboration and how data enabled us to target care where it was most needed. In the future, we see data and digital continuing to serve as an enabler for change and improvement across our system. We will stay current with new proven technologies. Where appropriate, we will choose low waste, low carbon footprint, repairable and upgradable technologies.

Shared health and care records

We will have a fully integrated single shared health and care record across BLMK by March 2023. This will help provide safe, personalised and high-quality care by enabling care professionals to access all the information they need about the people in their care. We are working to integrate the national care programme and by 2025 we will extend this to include information on social care.

"Get current, stay current"

Craig York - Chief Information Officer
Milton Keynes University Hospital NHS Foundation Trust

Data flow and connectivity

Information flows and connectivity between our partner organisations are vital to ensure we organise the right care at the right place at the right time. We must maintain and expand the infrastructure to support connectivity and integration. We will ensure that networks remain current and flexibly joined up. We will provide ease of access to our network and information while maintaining the highest level of data integrity and security.

Access through the NHS App

As outlined in the national plan for digital health and social care, the NHS App will be a central access point for residents to manage their health and care. By 2025, residents will be able - through the NHS app - to manage their appointments, contact their GP as well as access their health records.

Cyber-security

BLMK currently has some of the highest levels of data security in the country to ensure that the data we process and use always remains safe and secure. Data and Cyber security will remain a priority across our ICS to provide assurance and confidence to our residents and teams. All data will be accessible only to those who have the legitimate right to access it. We will comply with all national security requirements and compliance regimes as they are introduced.

Digital as an Enabler

System-wide consolidation

Across BLMK our residents expect that health and care organisations will be sharing information where they are working together to provide care to an individual. A move to system working will present an opportunity for BLMK partners to consolidate our investment in digital products and services, standardising our digital offer around those services which support good practice. This will reduce unwarranted variation, improve outcomes and deliver better value for the technology we are purchasing.

Moving to Cloud-based services

Our future direction will be to move more of our key data and applications gradually to a secure cloud-based model, whenever it becomes cost-effective to do so. This will allow BLMK partners to reduce reliance on on-site infrastructure, and allow teams to access applications and data wherever and whenever they need to.

"Setting out the Digital Strategy is critical in defining the direction for the ICS over the coming years putting the resident at the heart of what we are doing. Ensuring that we focus on delivering improved outcomes through the use of technology and joined up working." Lisa Beckett – Head of Customer Data and Insight Milton Keynes Council

Community diagnostic centres and community hubs

Early diagnosis is widely seen as a key enabler for improving health outcomes for residents and we are committed to bringing care closer to the community by connecting Community and Diagnostic Hubs to all the partners within our healthcare system.

Automation

As demand for care services increases and our population ages, we need to look for ways to enable our workforce to spend more time caring and less time on administration. We will therefore evaluate integration tools and Intelligent Automation technologies to identify areas where we could reduce administrative workload and enable information to flow seamlessly between organisations.

Digitisation of care home records

We have established a Digital Social Care Programme which supports care homes to become fully digitised by 2024, with a shared care record established. This will enable individuals to view their care records, update/contribute to their care plan, and access information on care provision, so that care recipients and unpaid carers can have greater involvement in their care.

Examples across our ICS

Initiative: Luton Population Frailty Assessment

Description: The frailty risk tool pools information from community health services, the Luton and Dunstable Hospital, local GPs and many more sources. It is organised in a user-friendly way, enabling teams across Luton to filter the data by key risk factors. This allows professionals to proactively identify and work with residents who are at the greatest risk.

Putting Data at the Heart of Decision Making

Care services are becoming increasingly complex and the pace of decision-making is becoming ever quicker. Putting the right information in the hands of the right person at the right time provides a mechanism to improve outcomes for residents. We therefore see Data as a key enabler for transforming care services.

BLMK Data Strategy

As outlined in our data strategy, it is paramount that we prioritise the capture of quality data across the ICS. Having access to accurate, consistent, timely, complete, accessible, and comprehensive information will enable our residents as well as our health and care professionals to take timely and accurate decisions. This will support consistently better experiences and outcomes. We will continue to invest in how we capture, store, share and use data for the benefit of our residents. We will use data ethically, and we will act effectively to make our data and information a powerful resource to continually improve service quality and efficiency.

"Taking a Digital approach across the ICS makes a fundamental difference to how we work together as partners to ensure our residents receive the optimal level of joined-up care available"

Clare Steward - Programme Director
Bedfordshire, Luton and Milton Keynes Integrated Care System

A single care record – using data to make better long-term decisions

We will join up data across our partnerships which will provide timely, accurate and appropriate communication with residents, supporting effective decision-making. This will enable BLMK partners to collaborate and to improve efficiency, quality, and experience for both residents and teams, improving our effective use of critical resources across our ICS.

Each of the partner organisations within BLMK already captures much of the data necessary to provide their health or care service to the residents. We have developed two integrated shared health and care records, which we will link to provide a single view across our ICS for direct care.

We will support our health and care teams with improved access to information for them to provide safe, high-quality services across multiple locations. This will help ensure that our residents will no longer need to repeat their experiences when going to a new health or care service.

Putting Data at the Heart of Decision Making

"Health and care will need to integrate if we are to meet the demographic and population health challenges of today and tomorrow."

John Syson - Director of Workforce
Bedfordshire, Luton and Milton Keynes Integrated Care System

Public Health and Population Health Management to improve health wellbeing and support

By exploring the potential of an ICS-wide public health observatory, we will combine local data with national population health management information to design a better health and care system for our ICS. This will allow us to better plan services across the system and also target preventative interventions to improve care outcomes.

A holistic view of the resident

Our health and care professionals will make the best use of information for our residents' care, providing a complete view of each individual. This will enable partner organisations to deliver and coordinate better care while recognising our residents' individual needs.

Examples across our ICS

Initiative: You can Do It!

Description: We are helping our residents build their digital skills in Bedfordshire. We organise workshops and provide our residents with devices as well as connectivity to ensure they are digitally included

Using data ethically

We will use data altruistically in ways that are clinically and professionally driven, digitally secure and appropriate to each health and social care setting. We will ensure that our approach to data ethics keeps on evolving as we learn, remaining in line with the Digital Ethics Charter and our BLMK commitment to Ethical Practice.

Digital skills for our teams and residents

Using data effectively requires some new skills and we recognise that transformation is not fundamentally about technology. It is about people and supporting our teams and residents in adopting innovations and new ways of working. We will provide training and support to develop the necessary skills so that our teams are confident in how they can use our data and digital services. Where relevant, we will make our digital resources accessible to residents, and we will have the right support in place to assist our residents and teams through this transition to shared digital solutions across our ICS.

Personalised Care

Personalised care and precision medicine

Increasingly, technology allows care decisions to be based on an individual's circumstances and tailored to the needs of individual citizens. This improves outcomes for residents.

We will make use of emerging technologies and the valuable insight they generate. This will enable colleagues and partners across our ICS to provide the right service in the right place at the right time. Examples of this include data-driven personalised health plans and decision support, as well as Artificial Intelligence which will increasingly be used for diagnostic support and optimisation of services.

"Additional resident participation in the design of digital solutions would be phenomenal"

Dr Tammy Angel - Consultant Geriatrician
Bedfordshire Care Alliance

Examples across our ICS

Initiative: Cardiovascular Remote Monitoring

Description: We are monitoring patients in the comfort of their own homes, giving them the opportunity to manage their health. Our clinical teams can monitor patients' vital signs remotely, reducing clinical time spent travelling and allowing our teams to proactively recognise signs of health deterioration and avoid admissions.

Remote care and connected devices

Self-monitoring and telecare is expanding rapidly with more new devices becoming available, enabling greater access for residents. To support independent living, we will expand access to 'remote-monitoring' solutions, which will help provide more accessible routes for our residents to proactively engage with health and care professionals. Where appropriate, this will be made available in our residents' homes, care homes or other domiciliary settings so that monitoring can take place closer to home and reduce unnecessary transfers to different care settings. Remote devices will help provide better continuity of care to our most vulnerable and/or isolated residents.

Remote monitoring solutions, such as Type 1 Diabetes monitoring products, enable our residents to save time, reduce the expense of travel and contribute to the Green Plan by greatly reducing the emissions produced when driving or commuting to the point of care.

These remote technologies will enable Health and Care services to implement 'virtual wards', allowing clinicians from primary care, community services and hospitals to make quicker judgements about whether people need treatment or admission. This will help minimise unnecessary hospital admissions, by supporting people to stay in the community and reduce extended stays in the hospital, allowing people to go home sooner.

Supporting Collaboration and Innovation

All the ICS partner organisations have a role in helping our system explore and evaluate innovations to improve the experience of both our teams and residents. Through the ICS we will enable collaboration and share what works, ensuring that we can make the best use of new digital technologies as they emerge.

Working in partnership

We will work in partnership with relevant institutions such as Universities, academic science networks, Public Health Observatories, the Local Government Association and others to review emerging technologies and models of care which are applicable to our ICS.

We will evaluate the potential for Trusted Research Environments to enable collaborative research using the FAIR data principles (Findable, Accessible, Interoperable and Reusable).

We will collectively adopt established national data standards, enabling interoperability to allow our teams and residents to connect to national programs.

Emerging technologies in health and care

With partners across our ICS, we will continue to evaluate and implement relevant emerging technologies such as telemedicine; acoustic monitoring; medication tools; artificial intelligence; machine learning and quantum computing. This will provide us with the new tools and capacity to stay relevant and provide the highest level of health and care to our residents.

Sharing what works and learning from others

We will make the most of our digital capabilities, regardless of which organisation hosts them, to ensure the best care for all our residents across BLMK. As part of the deployment of our digital strategy, we will identify best practice, share what we learn with each other, and with other ICSs. This will help us see what we do well and what we can do better. We will seek to enable our teams to collaborate more effectively by standardising processes and rationalising applications where appropriate. This means, for example, system-wide staff planning, a standardised approach to training and induction, and shared project management visibility.

Want to get involved?

Our digital strategy will remain a living document and will continue to be periodically reviewed as we adapt to challenges and opportunities. The "digital first, rather than digital only" approach will help us provide great health and care services to the residents we serve.

Your feedback is paramount for us to continue to evolve as a partnership and make sure we continue to get it right. If you have any questions, or would like to contribute, please contact us using our website at https://blmkhealthandcarepartnership.org or by email at blmkicb.contactus@nhs.net

We would also like to thank our partners for their support and contribution in the development of this strategy:

- *Bedford Borough Council*
- *Bedfordshire Care Alliance*
- *Bedfordshire Hospitals NHS Trust*
- *BLMK Integrated Care System*
- *Cambridgeshire Community Service NHS Trust*
- *Central Bedfordshire Council*
- *Central and North West London NHS Foundation Trust*
- *East of England Ambulance Service Trust*
- *East London Foundation Trust*
- *Healthwatch Luton Borough Council*
- *Luton Community Health Services*
- *Luton Council*
- *Milton Keynes Alliance*
- *Milton Keynes Council*
- *Milton Keynes Health and Care Partnership*
- *Milton Keynes University Hospital NHS Foundation Trust*
- *Newport Pagnell Medical Centre*

Jargon Buster

Jargon	Meaning
AI	Artificial Intelligence, software that examines data to find trends and insight.
BLMK ICS	Bedfordshire Luton & Milton Keynes Health and Care Partnership. Managing all the health and care organisations within BLMK.
Cloud based	Software and data that is not 'on-premise' and managed through a supplier who has contracts with one of the cloud service providers.
Consolidation	Reducing the number of similar systems by procuring more of a single system.
Data standards	An accepted and agreed-on standard for the format of data so that data can be coded correctly and shared in a meaningful way.
Digital	Used as a catch-all expression to describe information that is electronic, and the devices used to collect and view the information.
Digital divide	The gap between those that do not have internet access or appropriate digital devices and the average internet user.
Digital friction	The frustration felt when systems do not function as anticipated and appear to be hard to use.
FHIR	Fast Healthcare Interoperability Resources. A software language that enables information to be shared ensuring that field names and syntax is similar and can be understood by the receiving system.
HL7	Health-focused language of databases that enables data to be shared.
Integration	Software tools to enable data to flow between systems seamlessly in real-time.
Multi-channel	Different channels of communication. i.e. text, email, portals, NHS App, face to face.
Pseudonymised	Data that has the personal identification removed and replaced with a code that does allow the end-user of that data to know who the person is except with a software key.
Self monitoring and telecare	Devices in the home, either personal or given to residents, enabling them to send information back to the provider of care about their current health or care issues.
SMOMED CT	A medical coding methodology that enables information to be used in calculations and health planning.

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BLMK Integrated Care System Digital Transformation Plan

Year One Plan
26 July 2022 – V0.1 DRAFT

Data and Digital Transformation Foreword

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

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'What Good Looks Like' (WGLL) is the national framework for digital maturity, which is being used to accelerate digital and data transformation across systems. NHSE/I asked all emerging ICS's in late 2021 to review 'What Good Looks Like" for digital across the ICS and its' provider organisations.

WGLL is included as a must do in both the ICS design framework and NHS Operational Planning and Contracting Guidance. BLMK has developed a one-year plan for 22/23 against an agreed budget to support digital transformation digitisation.

To meet NHSE/I expectations BLMK undertook an expeditious assessment across the ICS and provider organisations to obtain an initial status against the WGLL success criteria. The initial assessment provided BLMK with a high-level overview of status and particular areas that require more focus over the next year.

Contents

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1a. Strategic Context

Through the development of the ICS and its 'Digital and Data Strategy' **five priority** areas have been identified through engagement with staff and communities in response to the NHS Long Term Plan.

What Good Looks Like (WGLL) success criteria for ICS' are themed through our priorities and development plans. These focus on:

- improving population **health outcomes**,
- improving **efficiency, experience & safety** to transform our population's health and care,
- supporting **environmental and economic sustainability** and
- data should be seen as an enabler to help **reduce inequalities**.

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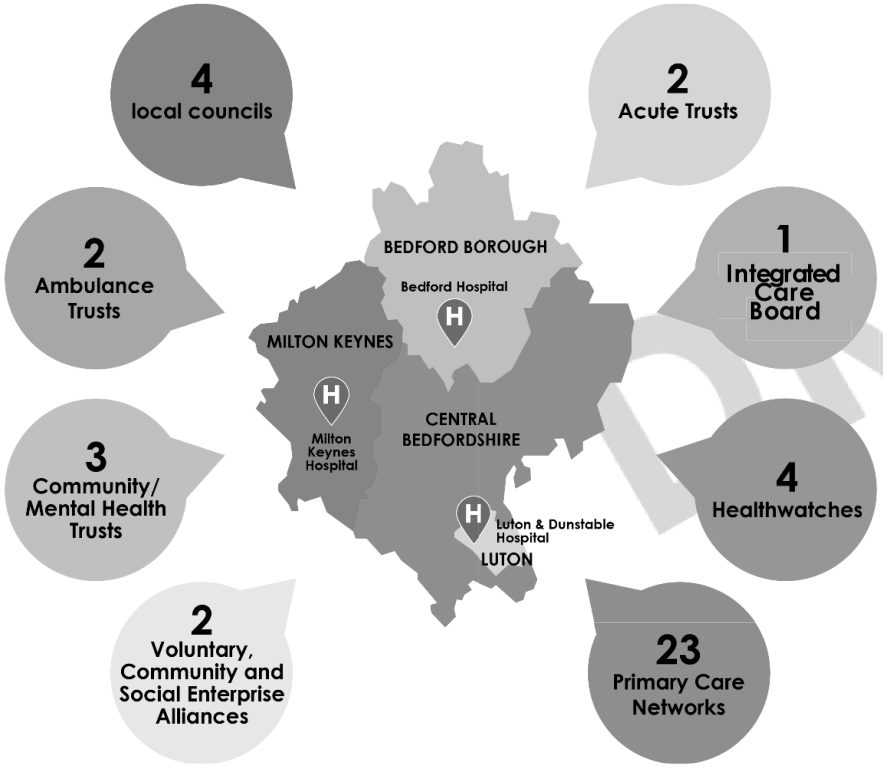
1b. ICS Partnership Journey & Digital Transformation Drivers

The formation of the ICS has been the next step in a journey involving the development of partnerships between multiple organisations. There are several key strategic drivers that have informed the co-development of the ICS Digital Transformation Plan.



Strategic Drivers including:

- ICS and partner strategies, in addition to;
- What Good Looks Like (WGLL)
- The Local Digital Declaration
- NHSE/I Operational Planning Guidance
- Healthwatch Digital Guiding Principles
- EPR Levelling up

Proud to be working together for better, more integrated services

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1c. Our Digital Vision

Our Partnership Mission is…

To work with our population to improve health and wellbeing, advance equality in our communities and make the best use of resources.

Our vision is…

Health and care service delivery is informed & supported by data and information, including population health, tailoring care to the individual.

Our Digital aim is…

- *Health and social care organisations share patient information about patients to provide better, quicker, safer care.*
- *Shared information helps identify residents with greater health and social care risks to support prevention and ensure the right care is delivered at the right time.*
- *Residents have access to their own health and care information, tools and support to help them to manage their own care.*

improves health and care data for residents

Acts as an enabler to reduce inequalities roll out our Shared Health & Care Record

Seeks to develop apps to **empower** residents to access their own information

improves the way we analyse data to provide more timely & improved care delivery

The principles which underpin how we will work across they system to achieve this are to:

- ✓ Keep the needs of our population at the centre of everything we do.
- ✓ Take a co-production approach, working together with local people and VCSE partners.
- ✓ Learn from good practice, adapting this to local circumstances.
- ✓ Take a subsidiarity approach: keep planning as close to delivery as possible.
- ✓ Be mutually accountable and support each other to deliver our priorities.
- ✓ Embed the principles of a learning system, taking into account the different starting points, and reflecting and adapting as we go.
- ✓ Listen to each other; be open about our challenges; focus on continuous improvement.

Our values are:

- Trust
- Respect
- Integrity
- Accountability
- Care and Compassion

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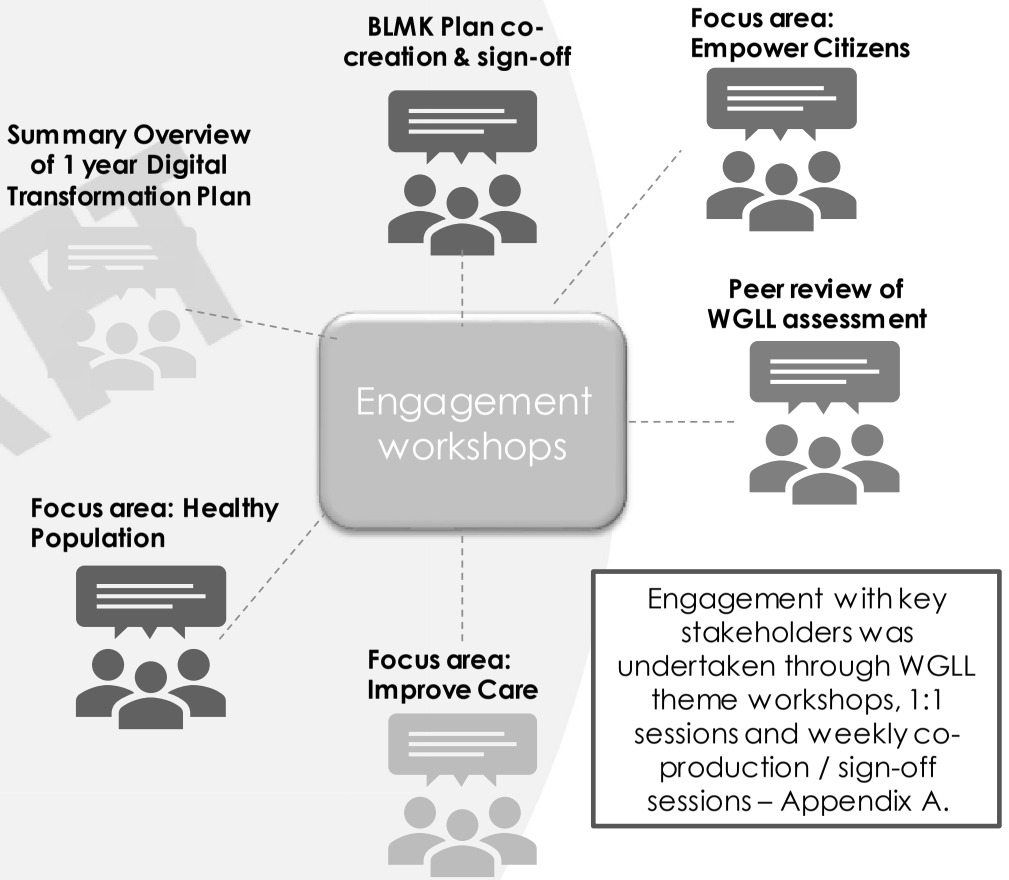
1d. WGLL Stakeholder Engagement

Over the past three months BLMK and MSE ICS' have worked collaboratively, peer reviewing areas of strengths and areas requiring more focus (please see Appendix B). The outcomes from this have supported the development (Appendix A) of the BLMK ICS initial one year Digital Transformation plan.

Following on from the One Year Digital Transformation plan BLMK will also seek to compile a 3 year Digital Roadmap and Investment Plan which is expected to be completed by Autumn 2022.



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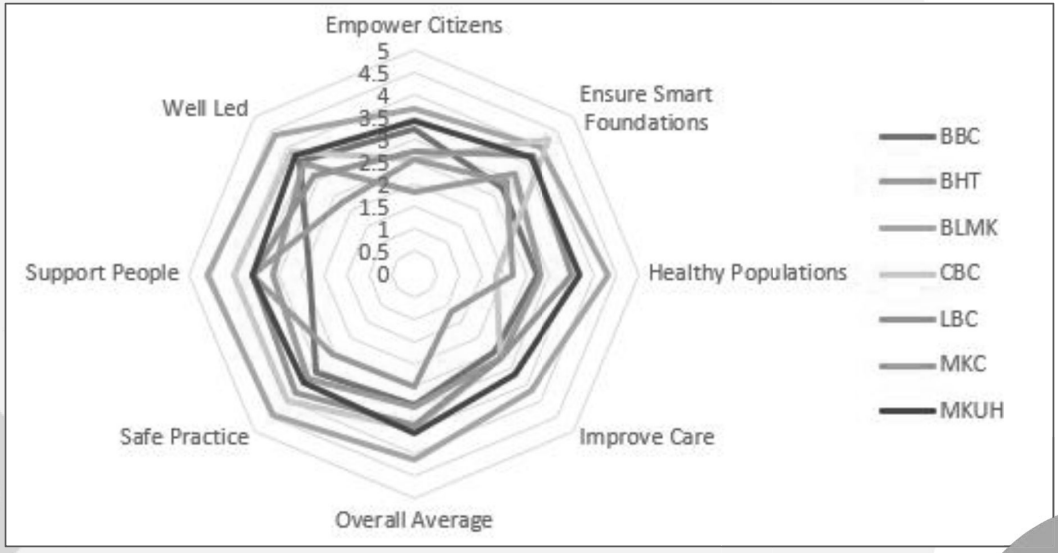
1e. BLMK High Level WGLL Self assessment Outcomes

Success Measure	Master Data
Empower Citizens	2.68
Ensure Smart Foundations	3.60
Healthy Populations	2.51
Improve Care	2.95
Safe Practice	3.69
Support People	3.54
Well Led	3.64
Overall BLMK Average	**3.23**



The overall view is that there are some core commonalities in strength areas such as **'Well-led, Supporting People and Safe Practice'**.

There are also areas that need a conjoined strategic focus in how we address **'Empowering Citizens Improving Care, Smart Foundations and creating Healthier Populations'** systematically.

Our one year baseline will look at our current unmoderated view and focus on these areas to ensure we embed a consistent approach across the system and benchmark on best-practice nationally.

The 7 success measures of What Good Looks Like – NHSEI

1f. What does this mean to our residents

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Increased awareness and understanding of what is being done to transform services through resident engagement

The ability to be more active, empowered partners in their own health and care

Increased choice and inclusion, with access to care available through multiple channels depending upon preference/needs.

"I have a choice between online and face-to-face health services, which are both as easy to access and give me the information I need. I understand how to decide which is better for me on any given occasion."

Personalised care based upon individual needs

"It is great that my GP knows all about my health & care history and can quickly offer a tailored solution"

Flexible services including ability to receive care at home or closer to home

Increased Digital Literacy for all

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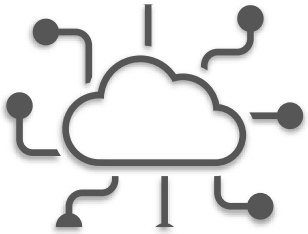
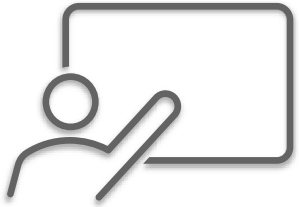
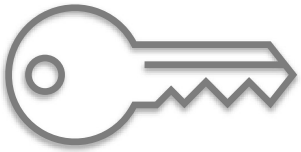
1g. What does this mean to our partners across Health and Care on behalf of our residents



Levelling up to core digital capabilities that support staff and the system overall

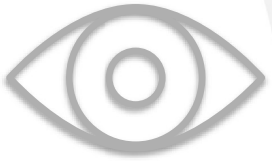


Recognition and support re digital options, with access to digital training

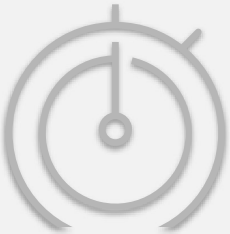


Access to more flexible, resilient and reliable systems

Flexible working with ability to work from multiple locations

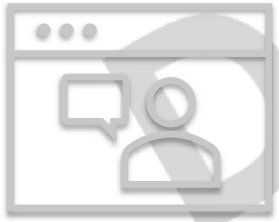


Improved visibility on availability, accessibility and use of resources

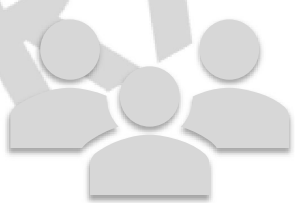


Timely and accessible insight enabling operational response to changing need

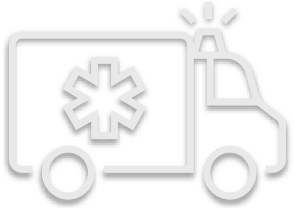
Stronger specialist networks and collaboratives



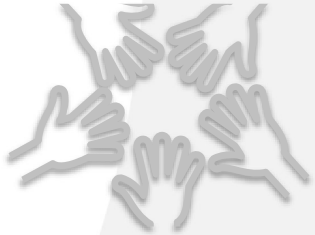
More automation to remove time spent on manual processing – check if this is in 1 year plan



Ability to assess population need trends and respond re service design



Improved access to integrated health and care records with a comprehensive view of the patient journey throughout the system – the right information at the right time to inform decisions



Linked data enabling integrated care, coordinated care and care management between partners eg: wrap around care provision to prevent health deterioration, optimisation of early intervention and earlier supported discharge

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2. Where are we now? - Examples of what has been achieved to date

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- ✓ PHM Strategy
- ✓ Data Strategy & Roadmap
- ✓ Digital Strategy draft

In addition to the development of key ICS Strategies, significant digital transformation has already been delivered:

Digital Achievement	Summary
PCN Hubs	Deployment of Primary Care hubs at scale, enabling GP practices on SystmOne within a PCN to share and view data relevant to care provision/planning
Remote Consultations (Online/Video)	Accelerated rollout of broader digital options for residents re Primary Care consultations
Care Home Remote Monitoring / Falls Pathway	Monitoring of Care home residents' vital signs/baseline observations to identify deterioration early. Partnering with the iStumble falls assessment tool and Raizer chairs to support patients who have fallen or require emergency lifting
Care Home Acoustic Monitoring pilot	Remote monitoring of residents at night to signal their potential risk of falling, disorientation and reduce sleep disturbance caused by carers checking on their wellbeing
MiiCare	Remote monitoring of residents at night to signal their potential risk of falling, disorientation and reduce sleep disturbance caused by carers checking on their well being
Yellow Bracelets	Real-time care package data availability across domiciliary, first responder, primary and secondary care

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2. Where are we now? - Examples of what has been achieved to date (Continued)

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Digital Achievement	Summary
Doccla Remote Monitoring (Virtual Ward / LTC)	Wearable devices to residents enabling care providers to monitor their vital signs remotely via a secure web browser
End of Life Beacon	Integration of End of Life pathway information across care providers to inform care
Digital Reception Pilot	Digital Literacy project to increase resident use of online services
Shared Care Record	Shared access to records across GP Connect, Primary and Acute Care settings
GP TeamNet	Collaboration Tool enabling closer Multi-Disciplinary Team PCN care approach
Milton Keynes Cancer Centre	New Hospital Programme model site enabling delivery of enhanced workforce/clinical care design
Elective Care Command Centre (Milton Keynes)	Hub enabling increase in elective patient activity, volume, and throughput with integration across Health and Social Care where available.
Patient Portal (Milton Keynes)	Resident engagement portal enabling access to results and appointment booking
ePMA (Bedford)	Electronic Prescribing and Medicines Admin across Luton Acute site
E-Take List	Electronic handover notes to enable more efficient workflows
Wifi Replacement (Bedford)	Implementation of enhanced site-wide wi-fi capabilities to enable remote working and digital care models
Orthopaedic (DASH) & Cancer Pathway enhancements	Patient Flow enhancement initiatives to increase efficiency

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3. How the components fit together the benefit of our residents

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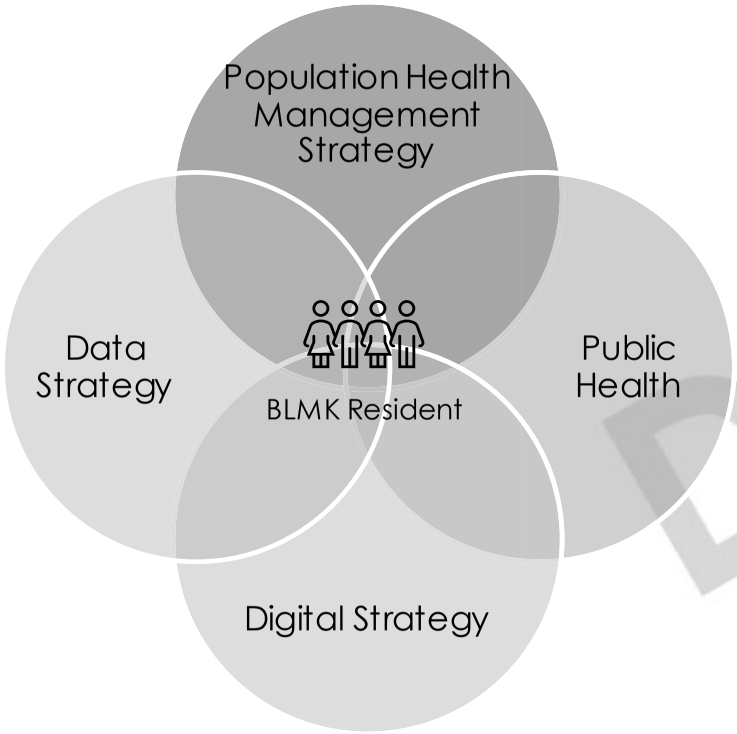


Components fitting together to benefit BLMK residents:

PHM Strategy: Supported by the digital and data strategies, PCNs, Places, Care Alliances and the ICS will be able to take evidence-based decisions to better target service transformation for improved outcomes.

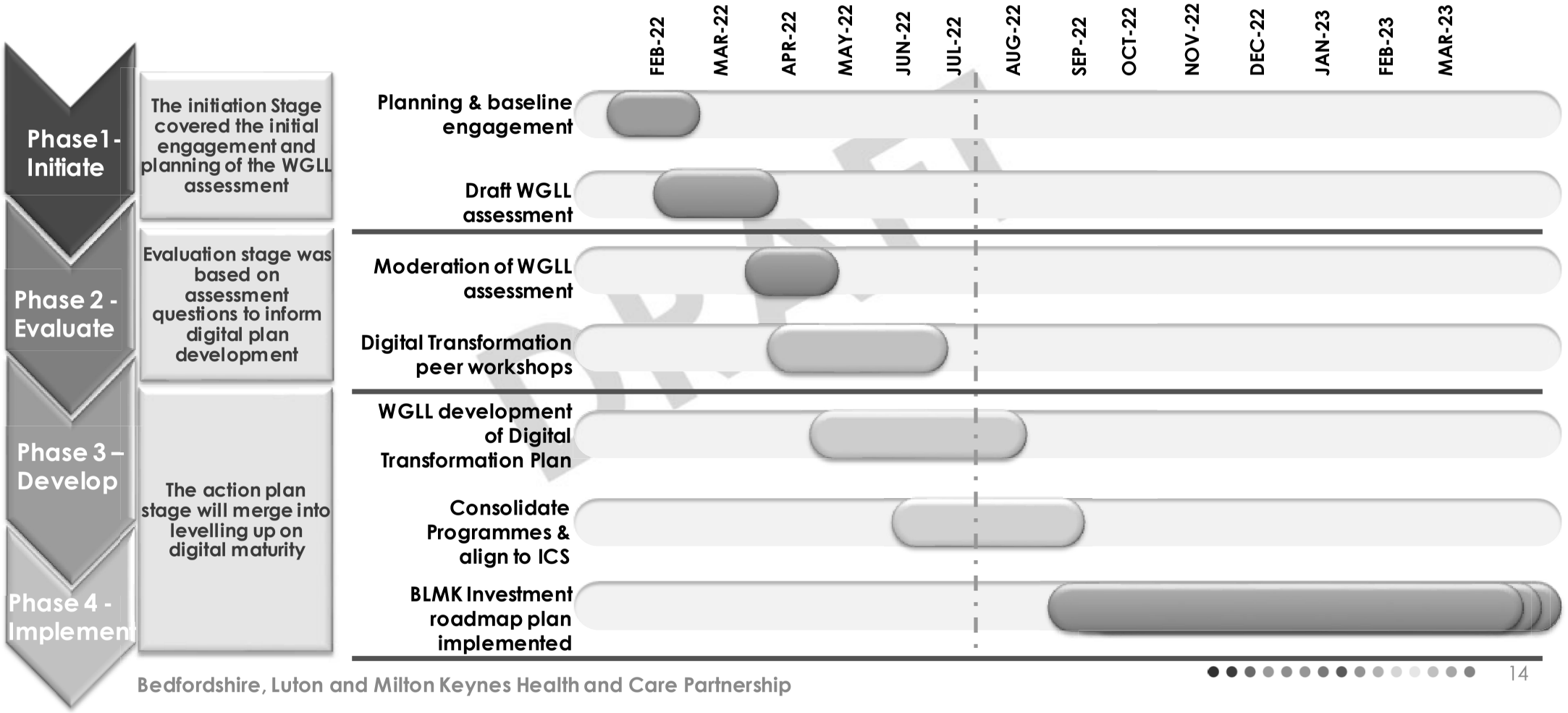
Public Health: With access to a wider range of data sets we will be able to better understand how our surroundings impact our health, and make changes that improve life opportunities and outcomes

Digital Strategy: To empower the resident to participate in their care provision, knowing that every part of their care is understood by the professionals delivering and planning healthier outcomes with and on behalf of BLMK residents

Data Strategy: a single version of the truth - to ensure that all health and care professionals and organisations within BLMK have access to the one version of the data in a timely manner

4a. BLMK ICS Digital Transformation Plan Year Timeline

Bedfordshire, Luton and Milton Keynes Health and Care Partnership



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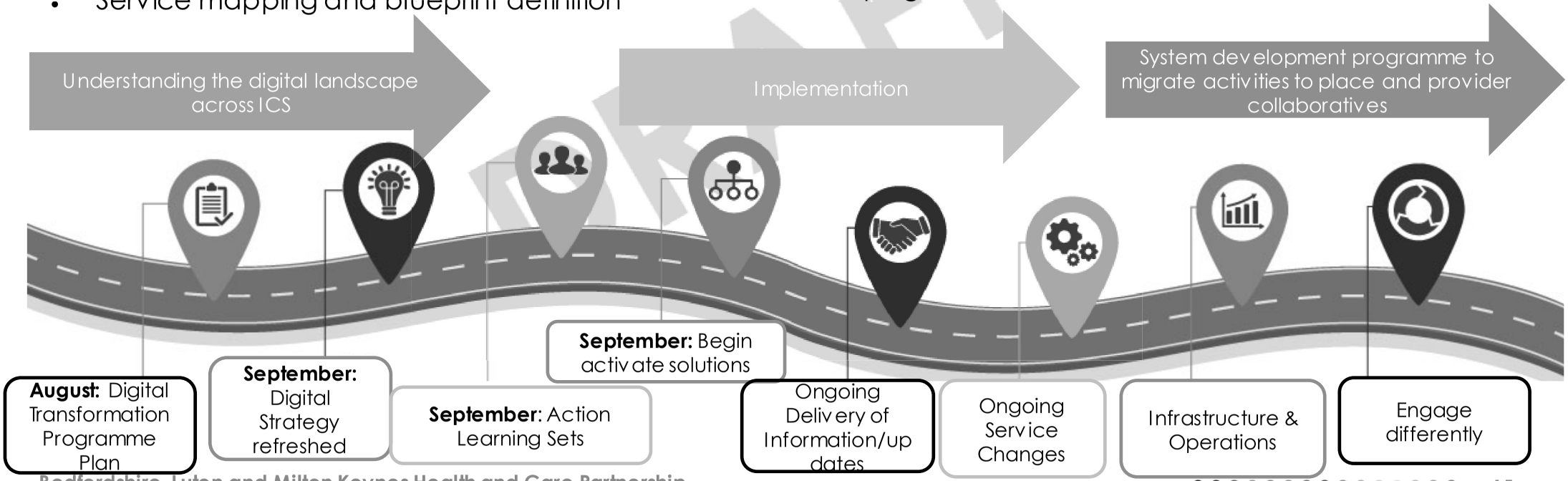
4b. Ongoing Development & Implementation Road Map

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Our road mapping approach includes:

- Digital initiatives prioritisation
- Digital roadmap implementation
- Service mapping and blueprint definition
- User research and customer insights analysis
- Customer journey mapping
- Developing measurement frameworks



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5a. Our Digital Transformation Plan Scope

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

What's In?

- ✓ Things that will make a difference to the collective health and care provision across BLMK and its borders to improve the health of the population.
- ✓ Things that will improve the ability to link systems, enabling information to flow securely and be available to people when they need it.
- ✓ Things that help residents to be better informed and empowered re their care
- ✓ Things that support digital inclusion and tailored services to meet the needs and preferences of residents
- ✓ Things that drive up ICS Digital Maturity in line with WGLL.
- ✓ Things that represent the best value for BLMK.

What's Out?

✗ Lower-level detailed operational delivery plans.

✗ BAU plans funded from local budgets.

✗ Things that don't meet ICS strategic investment or delivery principles.

✗ 'Stand Alone' digital solutions than cannot link to the broader ICS digital care record.

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5b. Key Focus Areas - Emergent Development Themes

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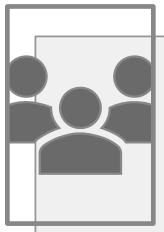
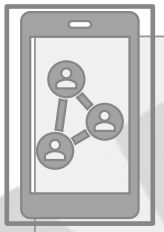
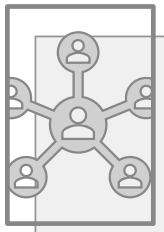


End to end visibility of records for Patients & Care Providers

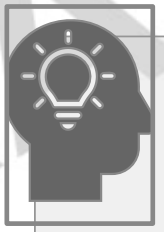
- Big Data
- Patient Flow / Journey



Increased Digital Literacy of our Residents and Workforce

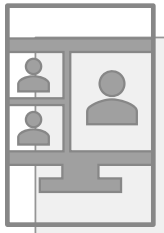


Digital Inclusion

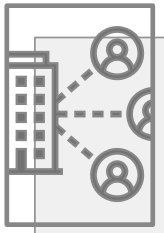


Flexibility of services / choices

- Ease of use and accessibility



Building a digitally-enabled workforce



Remote monitoring / Virtual Wards

6. Investment Plan 22/23 Summary

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

Workstream	Funding/Value	Funding/Resource In Place	2022/23											
			Qtr 1			Qtr 2			Qtr 3			Qtr 4		
			Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Acute Care	**Value / Resource Equivalent Value**													
Cyber Security (MKUH)	£ 245,000.00	Yes												
Elective Recovery: MSK Pathway MKUH)	£ 300,000.00	Yes												
Elective Recovery: Patient Portal Enhancement for Patient-centre write back to ePR (MKUH)	£ 325,000.00	Yes												
Elective Recovery: Outpatient PAS Enhancement & Deployment (MKUH)	£ 250,000.00	Yes												
Elective Recovery: Rapid Deployment of Command Centre (Capacity Mgt, Patient Flow, Command Centre) (MKUH)	£ 395,000.00	Yes												
Elective Recovery: Mpage Outpatient Workflow development & Integration across H&SC (MKUH)	£ 650,000.00	Yes												
ePR Levelling Up (BHT)	£ 2,500,000.00	No -Bid Outcome Pending												
Digital Pathology (BHT)	£ 1,000,000.00	Yes												
PACS Rationalisation (BHT)	TBC	No - Procurement Process Underway												
Ophthalmology Patient Flow	£ 200,000.00	Yes												
Microsoft O365 (BHT)	£ 270,000.00	Yes												
Trust wide MPI (BHT)	£ 110,000.00	Yes												
Virtual Wards (Acute model)	£ 3,221,000.00	No - Bid Outcome Pending												
Adoption Fund (Pathways)	£ 600,000.00	No - Bid In Development												

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6. Investment Plan 22/23 Summary (continued)

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

			2022/23											
			Qtr 1			Qtr 2			Qtr 3			Qtr 4		
Workstream	**Funding/Value**	**Funding/Resource In Place**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Primary Care	**Resource Equivalent Value**													
BLMK 1 Social Care Digital Managers	£ 230,000.00	Yes												
BLMK 2 Building on 20/21 Programme - Primary Care	£ 205,000.00	Yes												
BLMK 3 Patient Engagement Digital Reception	£ 50,000.00	Yes												
BLMK 4 LTC Technology Tools	£ 100,000.00	Yes												
BLMK 5 Digital First Dashboard	£ 40,000.00	Yes												
BLMK 6 Point of Care Testing MK Discovery	£ 53,000.00	Yes												
Social Care & Remote Monitoring	**Value / Resource Equivalent Value**													
DHSC - Implementation resource to support DSCR uptake and increased digitisation is Social Care - Acoustic Monitoring, Falls, Wifi and infrastructure audit	£ 406,810.00	Yes												
Partner Organisations Integrated Digital Programme: Remote Monitoring LTC/Care Homes (Doccla, Whzan, Yellow Bracelets)	£ 175,000.00	Yes												
Cyber Security (MKC)	£ 7,500.00	Yes												
Digital Care Record upgrades (MKC)	£ 15,000.00	Yes												
Shared Care Record (MKC)	£ 7,500.00	Yes												
Mental Health														
Remote Care: AHC for SMI	£ 120,900.00	Yes												
General														
Shared Care Record	£ 2,131,212.00	Yes												
Cyber Security - Future	TBC	No												
Diagnostics Capability	TBC	No - Network Bid Outcome Pending												
RPA - Future	TBC	No												

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7. Transformation Plan – key dependencies

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

For the ICS Transformation Plan to be successful the following elements are required:

- Awareness / familiarity ICS Governance and Strategies
- Ongoing commitment across H&CP organisations and provision of resources to deliver the ICS Digital Transformation Plan
- Resources available to support digital investment priorities
- Resident engagement throughout process
- Access to system digital initiative information to inform plan development
- Access to the Digital Programme PMO for project support
- Access to relevant partner staff for dedicated time to engage/develop
- Regular feedback sessions - partner availability throughout plan development
- Digital Leadership team sign off through phases

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Appendix A

Outcomes of Theme Summaries

A1 - Well Led 22/23

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Well Led National Guidance Criteria Summary:

The ICS has a **clear strategy for digital transformation and collaboration**. Leaders across the ICS collectively own and drive the digital transformation journey, placing **citizens and frontline perspectives at the centre**. All leaders promote digitally enabled transformation to efficiently deliver safe, high quality care.
Integrated Care Boards (ICBs) **build digital and data expertise and accountability into their leadership and governance arrangements**, and ensure delivery of the system-wide digital and data strategy.

Contributory BLMK initiatives:

- ICS Digital Transformation Board
- Social Care Digitisation Programme
- ICS Strategy Development (Data, Digital and PHM)
- Shared Care Record (ShCR)
- ePR Levelling Up

Planned Outcomes Summary:

- ICS Digital & Data Strategies
- Established ICS Governance incorporating ICS-wide clinical, operational, informatics, design and technical expertise representation
- Increase digital social care capability
- Levelling up of Acute ePR capabilities (BHT)
- ICS-wide Shared Care Record – improved data quality and access to information at the point of need

DRAFT

A2 – Ensure Smart Foundations 22/23

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Ensure Smart Foundations National Guidance Criteria Summary:

Digital, data and infrastructure operating environments are **reliable, modern, secure, sustainable and resilient**. Across the ICS, all organisations have well-resourced teams who are competent to deliver modern digital and data services. Investment in building **multidisciplinary teams** with clinical, operational, informatics, design & technical expertise to deliver the required digital and data ambitions. **Investment in a modern and simplified infrastructure,** considering consolidation where appropriate. Increased use and scope of **electronic care record systems** & delivery of an ICS-wide shared care record **(ShCR).** Plans incorporate progression towards **net zero carbon, sustainability and resilience** ambitions, also ensuring **robust cyber security**.

Contributory BLMK initiatives:

- Digitising Social Care Programme
- ePR Levelling Up
- Digital Pathology
- Ophthalmology Patient Flow
- Patient Portal Enhancement
- O365
- Shared Care Record
- Remote Monitoring
- Point of Care Testing Discovery
- Cyber Security
- Patient Flow Command Centre
- Trust-wide Single Patient Identifier (MPI)
- Digital First Dashboard
- PACS Rationalisation
- Virtual Wards
- MSK Pathway
- Mpage Outpatient Workflow Development

Planned Outcomes Summary:

- Increased digital social care ePR and mobile working capability
- ICS-wide Shared Care Record – improved data quality and access to information at the point of need
- Streamlined pathways and processes with more efficient use of staff resource incl. MDT approach
- Levelling up of Acute ePR capabilities (BHT)
- Remote working and flexibility re service design
- Reduced Unnecessary demand on Primary, Acute and Ambulance services
- Simplified systems and infrastructure
- Increased Pathology capacity and digital capability
- Earlier identification of deterioration and intervention
- Increased system capacity via remote care/care at home models
- Increased system resilience and security

DRAFT

A3 – Safe Practice 22/23

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Safe Practice National Guidance Criteria Summary:
Organisations across the ICS maintain standards for safe care, as set out by the **Digital Technology Assessment Criteria for health and social care (DTAC)** and **DCB 0129 and DCB0160**. Organisations routinely review system-wide security, sustainability and resilience. Centralised Cyber-security capabilities in place, supporting a **senior information responsible officer (SIRO), Clinical Safety Officer (CSO) and data protection officer (DPO)** adequately resourced **ICS-level cyber security function**.
Contributory BLMK Initiatives:
- Digitising Social Care Programme - Remote Monitoring / Virtual Wards - Primary Care Digitisation - Shared Care Record - ePR Levelling Up
Planned Outcomes Summary:
• Implementation of systems and architecture in accordance with data and security requirements • Robust Cyber Security function • Robust Clinical Safety and IG function and processes applied to digital transformation initiatives

DRAFT

A4 – Support People 22/23

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Support People National Guidance Criteria Summary:

The **workforce is digitally literate** and are able to work optimally with data and technology, with **remote working available** where appropriate. Digital and data tools and systems are fit for purpose and **support staff to do their jobs well**. **Digital First** approach developed and nurtured. Tools supported that will enable **frictionless movement of staff** and create system-wide **professional development and training opportunities**. Staff supported to **attain a basic level of data, digital and cyber security literacy, followed by continuing professional development**, along with the provision of access to digital support services 24-hours-a-day.

Contributory BLMK Initiatives:

- Social Care Digitisation Programme
- Point of Care Testing Discovery
- Shared Care Record
- Ophthalmology Patient Flow
- Patient Portal Enhancement
- Mpage Outpatient Workflow Development
- Patient Engagement Digital Reception
- Remote Monitoring
- PACS Rationalisation
- Virtual Wards
- Patient Flow Command Centre
- Outpatient PAS Enhancement
- Digital First Dashboard
- ePR Levelling Up
- Digital Pathology
- MSK Pathway
- LTC Technology
- O365

Planned Outcomes Summary:

- Digital first approach across partners and share innovative improvement ideas
- Partners support all staff to attain a basic level of data, digital and cyber security literacy
- Working with intuitive and easy to use systems
- Remote/Flexible working in place where appropriate
- Workforce have access to the digital tool required to perform their role efficiently and enable delivery of high quality care
- Workforce receive high quality training re the use of digital tools/systems as part of implementation and ongoing CPD

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A5 – Empower Citizens 22/23

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Empower Citizens National Guidance Criteria Summary:

Citizens are at the centre of service design and **have access to a standard set of digital services that suit all literacy and digital inclusion needs**. Citizens can access and **contribute to their healthcare information**, empowered **to take an active role in their health and well-being**. Develop a single, coherent ICS-wide strategy for **citizen engagement and citizen-facing digital services**, which is led and co-designed by citizens. Use of national systems and tools, supported by local ones, to provide people with the **ability to contribute to and access their health data,** having a clear **inclusion strategy** to ensure digitally disempowered communities can make the most of digital opportunities. Care plans, test results, medications, history, correspondence, appointment management, screening alerts and tools, are all highlighted as areas that citizens should be able to access.

Contributory BLMK Initiatives:

- Online Consultation
- Social Care Digitisation Programme
- Patient Portal Enhancement
- Patient Engagement Digital Reception
- Shared Care Record
- LTC Technology
- Remote Monitoring
- Virtual Wards

Planned Outcomes Summary:

- Digital communication tools to enable self-service pathways
- Residents are able to access and contribute to their health and care record
- Residents empowered to take an active role in their care plan development
- Residents and care practitioners ability to access services via different methods depending upon preference
- BLMK Digital Inclusion Strategy to support digitally empowered communities
- Residents empowered to use technology to access health and care services digitally

DRAFT

A6 – Improve Care 22/23

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Improve Care National Guidance Criteria Summary:

The ICS **embeds digital and data within their improvement capability** to **transform care pathways**, **reduce unwarranted variation and improve health and wellbeing**. Digital solutions enhance services for patients and ensure that they get **the right care when they need it and in the right place** across the whole ICS. All organisations make **use of the tools and technologies that support safer care**, such as EPMA and bar coding, and also provide decision support to help clinicians with best practice, provide **remote consultations, monitoring and care**, and enhance **collaborative and multidisciplinary care planning** through digital tools.

Contributory BLMK Initiatives:

- Social Care Digitisation Programme
- Point of Care Testing Discovery
- Shared Care Record
- Ophthalmology Patient Flow
- MSK Pathway
- Patient Flow Command Centre
- Patient Engagement Digital Reception
- Remote Monitoring
- PACS Rationalisation
- Trust wide Single Patient Identified (MPI)
- Patient Portal Enhancement
- Mpage Outpatient Workflow Development
- Online Consultation
- ePR Levelling Up
- Digital Pathology O
- Virtual Wards
- Outpatient PAS Enhancement
- LTC Technology

Planned Outcomes Summary:

- Use of data and digital solutions to redesign care pathways across organisational boundaries
- Use of data and digital solutions to ensure pathway efficiencies and best use of resources
- Access to the right information at the right time to ensure the right care plan
- Amplifying the use of digital tools and technologies that support safer care provision
- Collaboration and multidisciplinary care planning using effective digital tools/systems
- Use of digital solutions to tailor care to improve the wellbeing and care outcomes of residents
- Adoption of flexible service offerings including Virtual Wards and Remote Monitoring to provide care closer to home

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A7 - Healthy Populations 22/23

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Healthy Populations National Guidance Criteria Summary:

The ICS uses data to design and deliver improvements to **population health and wellbeing**, making best use of **collective resources.** Insights from data are used to **improve outcomes and address health inequalities**. Data used across organisations for **care planning**, as well as support the development and adoption of innovative **ICS-led, population-based, digitally-driven models of care.** ICS-wide intelligence platform with a fully linked**, longitudinal data-set** for population segmentation, risk stratification and population health management, with **organisations contributing both data and resources** to support this. Implementation of **ICS-created pathways and personalised care models** for at risk groups, which will use digital platforms to coordinate care across settings.

Contributory BLMK Initiatives:

-ePR Levelling Up
- ICS Data Strategy
- Shared Care Record
- LTC Technology
- Social Care Digitisation
- Remote Monitoring/Virtual Wards

Planned Outcomes Summary:

- ICS Digital & Data strategies
- Implement digital solutions and infrastructure that comply to standards that support the development of longitudinal care records for residents and Population Health data modelling
- Reduce inequalities through collective service planning based upon access to longitudinal care data-sets
- Improve the wellbeing and outcomes for BLMK residents through digitally-driven care models
- Use linked data to segment and risk stratify population cohorts to focus interventions and support integrated approach to care
- Develop insights from longitudinal records to transform pathways of care and enable earlier interventions to improve health & wellbeing
- Develop a whole system Population Health Intelligence function with combined analytical skills to support decision making across ICP/ICB

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Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

DRAFT

Appendix B

Key Contributors

B. Digital Stakeholder Engagement – Key Contributors

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

Organisation	Contact
BLMK ICS	Mark Thomas, Chief Digital Information Officer Clare Steward / Helen Haumann, Programme Director(s) (Digital Delivery) Brian Appleby – BCA Interoperability Lead Mark Peedle, Head of Digital (Primary Care) Amtar Ali, Digital Programme Manager (Social Care)
BLMK Alliance Directors	Alison Blair Programme Director Bedfordshire Care Alliance David Stout Development Director Milton Keynes Health & Care Partnership (MK Deal)
Bedford Borough Council Central Bedfordshire Council Luton Borough Council Milton Keynes Council	Simon White, Chief Officer for Health Integration Emel Morris, Chief Information Officer Patricia Coker, Head of Partnerships & Performance Luke O'Byrne, Head of Commissioning Zoe Bulmer, Business Information Manager Lisa Beckett, Head of Customer Data & Insight
Director / Chief Officer for Public Health	Ian Brown, Bedford, Central Bedfordshire and Milton Keynes Councils Susan Milner, Luton Borough Council
Bedfordshire NHS Foundation Trust Hospitals Milton Keynes University Foundation Trust Hospital	Dr. Tammy Angel, Consultant Geriatrician, Bedfordshire Care Alliance Clinical lead Gill Lungley, Chief Digital Information Officer Joshua Chandler, Chief Digital Transformation Officer Craig York, Chief Technology Officer Claire Orchard, Head of Digital Innovation

B. Digital Stakeholder Engagement – Key Contributors

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Organisation	Contact
Primary Care Networks – a Clinical Director from each local authority area	Paul Singer, Chief Clinical Information Officer
Healthwatch representative	Dave Simpson, Chair, Central Bedfordshire Healthwatch
BLMK Health and Care Professional Senate	A representative
VCSE	BLMK Nominated representative
ICS Partners (to be shared for information) Cambridgeshire Community Services NHS Trust East London Foundation Trust Central and North West London South Central Ambulance Trust East of England Ambulance Trust Fellow Healthwatch Partners Central Bedfordshire Healthwatch Bedford Borough Healthwatch Luton Healthwatch Milton Keynes Healthwatch	 Pete Reeve, Service Director Simon Fewer, Chief Technology Officer Nigel Tazzyman, Deputy Director of ICT and Head of Commercial Simon Edwards, Clinical Director Stephen Bromhall, Chief Information Officer Mike Carey, Programme Manager Diana Blackmun, CEO Helen Terry, CEO Lucy Nicholson, CEO Maxine Taffetani, CEO

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Integrated Care Board

Report to the Board of the Integrated Care Board
10. Estates Utilisation Review

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☐	Ways of working ☐	Estates ☒
Communications ☐	Finance ☒	Operational and Clinical Excellence ☐	Governance and Compliance ☐
Other ☐ (please advise):			

What are the members being asked to do?		
Approve ☐	Note ☒	Discuss ☐

Report Author	Nikki Barnes, Head of System & ICB Estates
Date to which the information this report is based on was accurate	16th September 2022
Senior Responsible Owner	Dean Westcott, Chief Finance Officer

Executive summary

This report provides a summary of work which has commenced under the new ICS Capital & Estates Oversight Group to review the utilisation of the BLMK estate, in preparation for a larger piece of work to update the ICS Estates/Infrastructure Strategy.

The scale of potential estates efficiencies which may be identified as part of this work is yet to be quantified.

Members of the ICB Board are asked to note the system Estates Utilisation Review work which has commenced, and representatives of partner organisations are asked to confirm their organisation's support to this workstream.

What are the available options?

N/A

Recommendation/s

The members are asked to **note** the following:

1) That a piece of work has commenced across the system to review the utilisation of the BLMK estate, with the aim of identifying efficiency gains.
2) This work programme will require support and input from all partner organisations within the ICS.

Key Risks and Issues

No direct risks in relation to this programme of work. However, realising any potential benefits/ efficiency gains will be dependent on support from partners, and achieving stakeholder/staff acceptance of any proposals.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

No direct risks identified.

Are there any financial implications or other resourcing implications?

Not at this stage.

How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

Potential for replacement of poor-quality old buildings with modern compliant premises, which will result in improved energy efficiency

How will / does this work help to address inequalities?

Estates Strategy enables delivery of ICS Clinical Strategies, which are focused on targeted focus on reducing health inequalities

The following individuals were consulted and involved in the development of this report:

Stephen Makin, Deputy Chief Finance Officer Estates leads across partner organisations
Next steps:
• Submission of Estates information from remaining partner organisations • Submission of detailed information regarding administrative estate across BLMK by partner organisations by end of September • Initial review of efficiency opportunities by November, to be managed via the ICS Capital & Estates Oversight Group
Appendices
N/A

Report to the Board Meeting of the BLMK Integrated Care Board
30th September 2022

System Estates Utilisation Review

1.0 Introduction

This report provides a summary of work which has commenced under the new ICS Capital & Estates Oversight Group to review the utilisation of the BLMK estate, in preparation for a larger piece of work to update the ICS Estates/Infrastructure Strategy.

The scale of potential estates efficiencies which may be identified as part of this work is yet to be quantified.

Members of the ICB Board are asked to note the system Estates Utilisation Review work which has commenced, and representatives of partner organisations are asked to confirm their organisation's support to this workstream.

2.0 Context

The ICS last completed a robust baseline of the health and care estate used across BLMK in 2018/19. How our staff work across the system, and models of care delivery have changed significantly in that time – in part due to an acceleration in digital advances during the pandemic. It is likely that some services and teams are not utilising their facilities as much as they used to, whilst pressure points have developed in other areas, e.g. as a result of significant workforce expansion within Primary Care Networks. It is therefore likely that there is the potential for efficiencies and/or improved value for money in relation to ICS expenditure on estates.

The Estates governance for the ICS has recently been strengthened, with the establishment of the monthly Capital & Estates Oversight Group (CEOG), drawing together Finance and Estates leads across the system. It is expected that guidance will be issued by NHS England in the next few months in relation to the development of ICS Infrastructure Strategies, which the CEOG will be responsible for on behalf of BLMK. Any work carried out before then to improve the quality of the information held about the system estate, and reviewing its utilisation, will support the work required for updating the BLMK Infrastructure Strategy.

3.0 Reviewing the utilisation of the BLMK Estate

Under the governance of the BLMK Capital & Estates Oversight Group, a piece of work has commenced to update the BLMK property database, and a phased approach to reviewing the utilisation of the collective system estate. Property information has been compiled from primary care, community and mental health. Some acute estate and Local Authority estate information is outstanding.

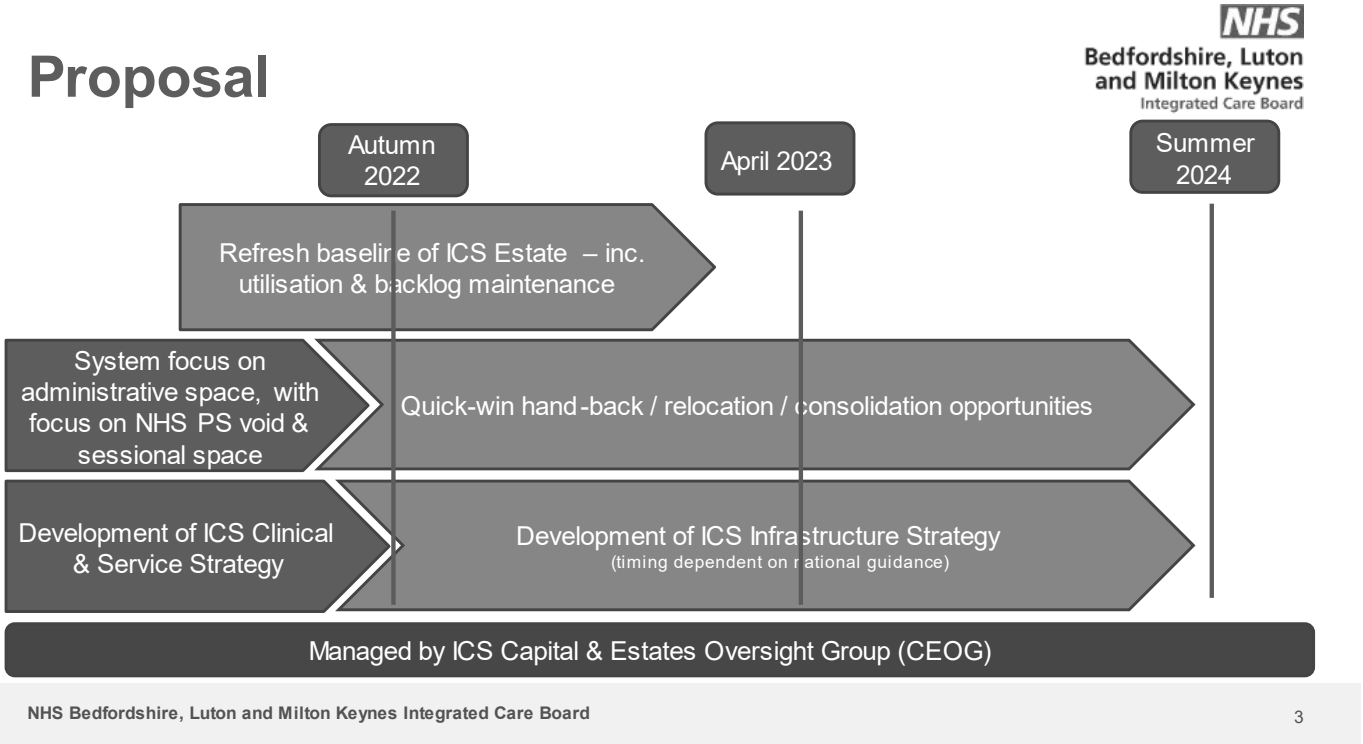
It has been agreed that the immediate focus will be on the administrative estate across all partner organisations, as it is considered this is the area with the most likely ”quick-wins” given the significant increase in agile working over the last few years. It is also an area with the greatest potential opportunities for applying a One Public Estate lens involving the Local Authorities.

All partner organisations have been issued with a template to help gather information relating to the following questions:

- Where is our administrative estate across the BLMK system?
- What do we already know about how well it is used? Where do we know we have a surplus of space?
- Where are there pressure points, e.g. services with inadequate space?
- What opportunities have already been identified and are already progressing?
- Where do partners have estates challenges? E.g. poor condition or inefficient buildings, properties which are poor Value for Money

This information will be collated by the group, with the aim of identifying a small number of significant opportunities to be explored further. The diagram below illustrates the anticipated timeline for this workstream.

A similar piece of work will need to be considered for the clinical/face-to-face areas of the BLMK estate. This is a larger project, and the approach to this will be agreed via CEOG members.



Opportunities

The Utilisation Review is aiming to identify:

- Opportunities for efficiencies (vacating buildings through rationalisation / relocation)

- Opportunities to address pressure points and/or improve Value for Money – to enable our services to achieve more within our current building stock.

It is fully recognised that decision-making within individual partner organisations will need to be respected as part of this process, and that there may be the need for staff engagement at appropriate stages.

A key area of focus will be on the potential to reduce charges to the ICB in relation to void and "sessional" space within NHS Property Services buildings. The total void costs per annum are £699,197 per annum (for 16 properties/part-properties spanning the four Local Authority Places of BLMK), and the total cost of unused "sessional" space is £294,137 (14 properties). The opportunity savings will be quantified as part of this programme of work.

The outputs from this work can feed into Place level Estates discussions as appropriate, including One Public Estate forums with the involvement of wider partners (e.g. Police, Fire Service).

4.0 Risks

There are no direct risks in relation to this programme of work. However, realising any potential benefits/ efficiency gains will be dependent on support from partners, and achieving stakeholder/staff acceptance of any proposals.

5.0 Summary

A piece of work has commenced across the system to review the utilisation of the BLMK estate, with the aim of identifying efficiency gains. Initial findings from the first phase of this work in relation to the system's administrative estate are expected by November, dependent on timely return of information from partners.

This work will feed into the wider programme expected to commence later this year in relation to refreshing the ICS's Infrastructure Strategy.

Members of the Board are asked to note this programme of work, and the support required from all ICS partners to take this forward successfully, and representatives of partner organisations are asked to confirm their organisation's support to this workstream.

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Integrated Care Board

Report to the Board of the Integrated Care Board
11. Quality and Performance Statement

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☒	Workforce ☒	Ways of working ☒	Estates ☐
Communications ☒	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☒
Other ☐ (please advise):			

What are the members being asked to do?		
Approve ☐	Note ☒	Discuss ☐

Report Author	Maria Laffan Deputy Chief Nurse, Carol Davies, Head of Performance
Date to which the information this report is based on was accurate	13/09/2022
Senior Responsible Owner	Anne Murray – Director of Nursing Programmes, Maria Wogan, Chief of System Assurance and Corporate Services

Executive summary

This paper summarises key areas of quality and performance concern across the Integrated Care Board. The focus is on areas of impact to patients and outcomes, safety, safeguarding and experience. A dashboard of performance and quality KPIs is also attached. A series of more detailed papers have been shared at the Quality and Performance Committee in September in order to provide an update on the position and confirm and agree key actions to mitigate impact on patients.

The Quality and Performance Committee received an overview of key areas on the risk register.

A forward plan for the Committee has now been agreed so that a deep dive approach can be taken into system pathways with more of a detailed oversight to include oversight of incidents, performance, patient feedback and complaints and adherence to relevant guidance as an example. All relevant partners and key stakeholders will be included in the deep dives.

Future reports will also include safeguarding themes and learning from multi agency partnership work.

The System Quality Group is now well established which enables the sharing of intelligence and key risks of concern from all stakeholders and providers. This Group reports to the Quality and Performance Committee and is seen as an essential forum for openness, sharing of relevant information and agreeing actions. The System Performance and Delivery Group is also well established and shares progress and key risks in relation to system performance including preparation for winter and management of significant incidents such as Operation London Bridge. The Quarterly System Oversight and Assurance Group (SOAG) of System Chief Executives provides the most senior executive forum for collective accountability, assurance, and management of system risks. The next meeting of this Group is taking place on 4th October 2022 and will also be attended by Regional colleagues as part of the Regional assurance process for ICBs.

In order to develop this partnership working in line with previous conversations with Board members across BLMK, a development day for the System Quality Group is planned for 25th October. The aim being to develop more of a transformational approach to quality improvement.

Development work is underway with system partners to improve the way in which quality and performance is reported to the Board of the ICB, its committee's and the places. An initial discussion was held with performance reporting colleagues from NHS Trust and local authorities in September and a community of practice has been established to co-produce an improved approach which supports timely reporting of data, supported by analysis to enable effective decision-making and risk management at all levels of the system. The Board can expect to see improvements in reporting over the next six months and feedback from Board members on the reports produced would be very welcome.

What are the available options?

As described in relation to individual items in the paper.

Recommendation/s

- Note the areas of risk identified and work underway to support mitigation and improve delivery.
- Note the development day for the System Quality Group 25th October and support relevant colleagues from partner organisation to attend this day.
- Approve the focused approach to the quality and performance report and note the ongoing development work on reporting for the Board, its committee's and places.

Key Risks and Issues

The members are asked to **note** and **discuss** the following risks and the mitigating actions described in the report:

- Risks to patient outcomes associated with system pressures and delays to services due to the impact of covid.
- The need to identify the patient impact following the Cyber-attack on the 111 service's Adastra technology.
- CQC position on the ambulance services provided to BLMK residents
- Risks to emotional wellbeing and mental health for children and young people.
- Current position with Written statement of actions for Special Educational Needs and Disability (SEND) services for Luton Borough Council and Central Bedfordshire Council.
- Challenges and ongoing requirements for Maternity services due to national reviews.
- Challenges in delivering health assessments for Looked after Children.
- Impact on services and staff due to Workforce shortages.
- Recognition of the new patient safety incident management framework and the need to implement a new approach across system partners.

Have you recorded the risk/s on the Risk Management system?	Yes ☒	No ☐

- N&Q 4 – Patient outcome Covid impact
- SG-634 – 111 cyber attack
- N&Q 2 – CQC ambulance
- N&Q 11- Mental health CYP
- N&Q 1- SEND
- N&Q 13- Maternity
- SG-637- IHA/RHA LAC
- N&Q 21- workforce

Are there any financial implications or other resourcing implications?

N/A

How will / does this work help to address the Green Plan Commitments?

Not Applicable

There are no specific links to the green plan in this paper. Reporting on performance against the green plan is commencing and will be included in future performance reports.

How will / does this work help to address inequalities?

Inequalities will be considered in all aspects of transformational work. Considering if communities are affected adversely using the Equalities Impact Assessment Process.

The following individuals were consulted and involved in the development of this report:

Members of the System Quality Group, the Performance and Delivery Group and the Quality and Performance Committee.

Next steps:

Ongoing work with providers and Local Authority teams to ensure sharing of information, identification of learning and potential transformation opportunities.

Appendices

Appendix A – Month 3 – BLMK Performance Summary Report

1. **This paper outlines BLMK ICB quality and performance risks and areas of concern**

   All risks identified in this report have been escalated in discussion at the ICB Quality and Performance Committee and have system oversight on the potential for mitigation and management of these risks becoming issues for the organisations, system and the Bedfordshire, Luton and Milton Keynes population.

   Further transformation opportunities are to be considered and developed within the partnership.

Key Performance and Quality summary and risks

2. **Elective Recovery** – Good progress has been made in the reduction of the 104+ weeks waits and the focus is now on the reduction 78+ week waits. Patients with the most urgent needs continue to be prioritised in NHS and independent hospitals across the system. Trusts continued to implement patient-initiated follow-ups across different specialities. This enabled the patient to access a consultation through video conferencing technology using their preferred device. We also maximised our advice and guidance service to support primary care by providing specialist clinical advice to clinicians. This allows care to be directed to the most appropriate setting and support the safe reduction of unnecessary outpatient appointments.

3. **Echocardiogram breaches at Bedfordshire Hospitals Foundation Trust**

   Diagnostic workforce issue impacting ability to undertake echocardiogram tests and report in a timely way.

   Action: Trust outsourcing to independent provision to support

4. **Cancer** – **Risk of poor outcomes for cancer patients**

   Impact on some cancer pathways noted in serious incidents due to treatment delays. Challenges across diagnostic elements of tumour specific pathways. Limited resource in workforce to support.

   Continues to be a prioritised service to give all patients fair and timely access to diagnostics and treatment. System partners worked together with oversight from the Cancer Board to improve the patient pathway and support recovery and restoration of cancer services.

   All Trusts in England have been assessed and placed into tiers based on confidence in reducing backlogs to pre-pandemic levels by March 2023. Bedfordshire Hospitals Foundation Trust (BHFT) is currently Tier 1 and is receiving additional support/oversight from NHSE. As at 11th September, BHFT are nationally positioned at 43, with Milton Keynes University Hospital (MKUH) at 37. BHFT still remain in Tier one, however the Cancer Alliance have recommended to the National team that they be removed from Tier one, due to assurance provided around oversight and processes in place. Confirmation of this will be fed back following consideration. MKUH are not in tier 1 or 2.

   Action: Quality oversight included at Cancer Board following focused worked with teams in provider trust cancer units.

5. **Mental Health 'Perfect Week'** exercise has been extended into a second week which ended on 4th September, to maximise the impact and ensure as many people as possible could be discharged. Bedfordshire Police have been involved in developing the expansion of the Street Triage model to increase available hours officer over the winter commencing from November. Seasonal drop in Improving Access to Psychological Therapies activity but still on track against plan and significant improvement in waiting times in Luton.

6. **System pressure across Urgent & Emergency care – ICB quality risk**

   Concerns for quality and safety impact for residents accessing BLMK Urgent and emergency care services. Systems serious incident investigation concerning patient impact from ambulance delays. Increasing delays in local A&E departments, impacting performance

standards and patient trolley waits (patients waiting over 12 hours in A&E following a decision to admit. Increasing systems pressure (Acute trusts frequently on Opel 4).

Ongoing use of escalation beds, exit block (not being able to discharge patients with no criteria to reside) impacting flow, Emergency Departments (ED) demand continues to increase against pre-Covid baselines, large volume of patients with minor illnesses attending ED, workforce challenges across the system. Capacity continually assessed to ensure safe care can be provided to patients with most urgent need. Discharge planning starts on admission day for patients able to go home within 72 hrs. Separate report on the Board agenda regarding Winter Planning.

Action: A deep dive will be presented at the next committee.

7. Adastra outage – 111 impacts

Software cyber-attack in August interrupted service provision – long delays for patients accessing 111. Risk of poor sharing of safeguarding concerns. National recovery in place – services resolved. Following go live, call answering times and call abandonment rates improved significantly and direct booking was restored. Action: impact being assessed

Children and Young People

8. Demand and capacity availability for Child and Adolescent Mental Health (CAHMS) services including Tier 4 beds, therefore associated risk of inappropriate care settings for children. - ICB Quality Risk

Deep dive held and reported to Quality and Performance Committee to focus on challenges and identify opportunities.

Action: ELFT will open Evergreen in-patient unit in December which will be an 8 bedded unit in Luton for specialist short term care for children with severe or complex mental health difficulties. Programme of work on CAMHS transformation and improvement, focus on support in schools, supporting Primary care, increased digital options, information and support, co design of services with Children and Young People (CYP).

Priority for CYP Transformation Board in support of Place priorities

9. Lack of co-ordinated pathway for children with eating disorders

Significant increase in demand from children and young people with eating disorders. Monthly average number of referrals across BLMK in 2020/21 was 25. Increased in 21/22 to 29. YTD 2022/23 is 34 – 35% increase on 2020/21 and 16% increase on 21/22. Demand and capacity and skill mix analysis undertaken. Risk of not achieving the 4 week non-urgent wait target for Children and Young People Eating Disorders (differential at place).

Action: Funding allocated to eating disorders from the mental health investment standard, medium term funding and service development funding. Flexible in reach services being delivered by CAMHS to support CYP in hospital or in crisis at home. Mobilisation of the mitigated plan to meet national trajectories for eating disorders by Q4 22/23 is being delivered with oversight by ICS BLMK Mental Health Delivery Group.

10. Risk of poor outcomes for women accessing maternity services across BLMK

Following the recent National publication of Ockendon report essential and immediate actions were identified for local services. Significant programme of work across all areas of provision. Oversight through Local Maternity and Neonatal System Board. Further review awaited from Kirkup report on East Kent when published.

Action: Focused areas of reporting planned to Quality and Performance Committee

11. **Community Services** – Waiting lists and backlog recovery plans are in place however recruitment remains challenging and staff sickness/leave/vacancies presents risk to operational capacity. Across Podiatry and Wheelchair services identification of backlog threshold to cover early recognition of service delivery issues and trigger early intervention management to prevent or identify challenging trends in wait times.

12. **Impact of Covid on delivery and performance and linked risk of impact and poor outcomes for patients. ICB Quality Risk**

Positive COVID numbers had continued to impact on a number of areas of practice across BLMK, however from mid/late August there has been a steady improvement across local acute providers, residential care homes and domiciliary services with no covid outbreaks at acute providers in August.

Action: Recovery programmes in place to return to improved performance across services and provided better access to health. Difficult to understand real risk on outcomes – some evidence on treatment delays identified through serious incidents – not all known/reported. Continue to monitor impact

13. **Workforce challenges across system**

Significant workforce issues across all areas of provision. International recruitment successful in some areas in nursing and therapies. Some areas such as community providers are challenged with impact of rising fuel costs in the provision of domiciliary services. Seeking further support, hardship funding available.

14. **SCAS – South Central Ambulance Service – ICB Quality risk**

Provider of ambulance service to MK population – Recent CQC rating of inadequate – Particular concerns in leadership, safeguarding & safety.

Action: Further work with lead commissioner Berkshire, Oxfordshire, Buckinghamshire (BOB) ICB (Berkshire West) leading contractual and quality management on behalf of associate commissioners to ensure oversight and understand impact to local services.

15. **SEND Written statement of Action BLMK ICB/Luton Borough Council ICB Quality Risk**

Revisit due from CQC/Ofsted inspection in Autumn 2022. Potential risk of not making significant improvements in a timely way in relation to access to services, services working together in a co-ordinated way, including planning and assessment.

Action: Place based Improvement Board in place, chaired jointly by Director of Children Services and ICB Director of Nursing.

16. **SEND – OFSTED /CQC Revisit outcome Central Bedfordshire Council**

Recent revisit CQC/OFSTED 4th-6th July – sufficient progress in 3 of the 6 areas of weakness identified at initial inspection. Three areas need further progress: Quality of Education and Health Care Plans, Leaders' oversight and the need to understand the outcomes for children particularly those who are out of area and those on part-time timetables.

Action: Place based Improvement Board in place, chaired jointly by Director of Children Services and ICB Director of Nursing

17. **Initial Health & Review Health Assessments for Looked After Children**

Initial Health Assessments and Review Health Assessment are currently not delivered in expected timeframes – This is mainly due to paediatricians' capacity to undertake assessments.

Action: Close working with Local authority teams to monitor delivery and consideration of new models underway. Oversight included in Safeguarding nurses roles

18. Patient Safety Incident Response Framework (PSIRF)

The new Patient Safety Incident Response Framework - PSIRF was published on the 16th of August 2022. Requirements stipulated in this new framework need to be implemented before September 2023. This framework fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement.

PSIRF advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected, embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management. The implementation of PSIRF will not be achieved by a change in policy alone it requires work to design a new set of systems and processes.

Action: Localised plans across system under development. Further information to follow.

For details, please click

https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-andsupporting-guidance/

Key Quality and Safety Indicators and risks

19. In June there were 18 cases of C.diff across the ICB and 10 cases at BHFT and 4 at MKUH trust wide. There was 1 case of MRSA across the ICB (community onset) and 1 case at MKUH.

20. Ongoing rise in the number of referrals for safeguarding across BLMK. Reviewing and streamlining pathways for adult and children safeguarding referrals. Working with safeguarding partnership boards to identify ICB Safeguarding priorities.

21. Lakeside hospital is now successfully closed with all patients relocated in alternative provision.

22. 2 Central Bedfordshire care homes rated inadequate by CQC – improvement nurses working closely with care standards teams.

23. 16 Serious Incidents have been reported to BLMK ICB in June 2022, giving a year to date total of 62.

24. Conclusion

This report gives an overview of high-level performance and quality risks and activities that are current, it is not aimed to be inclusive of all areas.

A more focused report will be planned for future boards based on the development of new approaches and governance.

Appendix A - Month 3 – BLMK Performance Summary Report

Area	BLMK ICB	Threshold	Frequency	Latest Data	Achievement	Trend	YTD	Ranking	Regional Average (ICB position vs region)	What does good look like
Elective Recovery	RTT - % Patients Waiting 18 Weeks or less	92%	M	Jun-22	58.74%	⇩	●	8 / 14	59.51%	High is good
	RTT - Number of 104+ Week Waits	n/a	M	Jun-22	9	⇧		9 / 14	15	Low is good
	RTT - Number of 78+ Week Waits	n/a	M	Jun-22	491	⇧		12 / 14	457	Low is good
	RTT - Number of 52+ Week Waits	n/a	M	Jun-22	5919	⇩		13 / 14	3,238	Low is good
	Diagnostics Tests - 6 Week Waits	≥1%	M	Jun-22	33.09%	⇩	●	8 / 14	32.89%	Low is good
Cancer Care	Cancer -2 Week Waits Standard	93%	M	Jun-22	76.22%	⇩	●	3 / 14	67.51%	High is good
	Cancer - 28 Day Faster Diagnosis Standard	75%	M	Jun-22	70.37%	⇧	●	3 / 14	66.22%	High is good
	Cancer - 62 Day GP Referral	85%	M	Jun-22	52.16%	⇩	●	9 / 14	57.29%	High is good
	Cancer - 104+ day waits	0	M	Jun-22	43	⇩	●			Low is good
Urgent Emergency Care	Ambulance - 30 minute Handover Delays (Daily Average)	n/a	M	Jul-22	32.61	⇩				Low is good
	% ED Attendances that result in emergency admission	n/a	M	Jul-22	23.65%	⇧			25.20%	High is good
Primary Care	Appointments in GP Practice - % Face to Face	75%	M	Jun-22	75.17%	⇩	●	3 / 14	68.51%	High is good
Adult Mental Health	72-Hour Follow Ups	80%	M	May-22	92.00%	⇧	●			High is good
	SMI Healthchecks	Q1 - 3800	Q	Q1 2022/23	3944	⇧	●			High is good
	Dementia Diagnosis Rate	Q1 63.16%	M	Jun-22	63.50%	⇧	●	5 / 14	59.20%	High is good
	IAPT Access	2088	M	May-22	2075	⇧	●			High is good
	Early Intervention in Psychosis (EIP)	60%	M	May-22	85%	⇧	●			High is good
	Inappropriate Out Of Area Bed Days	n/a	Q	Q4 2021/22	725	⇧				Low is good
Learning Disability & Autism	Learning Disability Healthchecks	Q1 6.81%	M	Jun-22	10.36%	⇧	●			High is good
Children and Young People (CYP) & Maternity	Number of CYP accessing mental health services	16325	M	May-22	16613	⇧	●			High is good
	CYP Eating Disorders - Routine	95%	Q	Q1 2022/23	83.03%	⇧	●	8 / 14	63.17%	High is good
	CYP Eating Disorders - Urgent	95%	Q	Q1 2022/23	78.57%	⇧	●	8 / 14	49.42%	High is good
	Perinatal Mental Health Access (unvalidated)	107	M	May-22	351	⇧	●			High is good
Community Services	Children's Wheelchairs - % received in 18 weeks	Q1 77.27%	Q	Q1 2022/23	75%	⇩	●			High is good
	Urgent Community Referrals - 2 hour Standard	70%	M	Jun-22	97%	⇧	●		79%	High is good
	Urgent Community Referrals - Responses within 2 hours	669	M	Jun-22	350	⇩	●			High is good
Quality & Safety	Serious Incidents	0	M	Jun-22	16	⇧				Low is good
	Infection Control - C-Difficile	12	M	Jun-22	18	⇩	●	12 / 14	12.07	Low is good
	Infection Control - MRSA	0	M	Jun-22	1	⇧	●	9 / 14	0.5	Low is good

Key	
Trend Arrows	
⇧	Improving
⇩	Deteriorating
⇔	No change
Achievement RAG	
	On Track
	Off Track
YTD	
●	YTD On Track
●	YTD Off Track
Regional RAG	
	ICS vs Regional Average
	ICS vs Regional Average

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
12. Finance Report (July 2022 - Month 4)

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☒	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☐	Ways of working ☐	Estates ☐
Communications ☐	Finance ☒	Operational and Clinical Excellence ☐	Governance and Compliance ☐
Other ☐			

What are the members being asked to do?		
Approve ☐	Note ☒	Discuss ☐

Report Author	Finance Department
Date to which the information this report is based on was accurate	17/08/2022
Senior Responsible Owner	Dean Westcott, Chief Finance Officer

Executive summary

This paper sets out the 2022/23 BLMK ICS financial position at month 4 (July 2022) for revenue and capital spend. The system is reporting a £1.6m income and expenditure deficit to plan at Month 4 but forecast to deliver a breakeven position.

System efficiency plans are £3.6m below target year-to-date but forecast to deliver the full £55.6m by the end of the year. It should be noted that the under achievement of year-to-date savings is not having an adverse impact on the system financial revenue position.

The ICS will manage capital schemes within the capital limits (CDEL) imposed upon it by NHS England.

Risks to achievement of the system financial plan have been identified and are in the process of being quantified, along with mitigations. These will be further developed ready for the next Finance & Investment Committee.

What are the available options?

Not applicable

Recommendation/s

The Board is asked to **note** the following:

1) the month 4 and forecast position for revenue and capital
2) the risks to the financial forecast

Key Risks and Issues

The key risk is the failure to deliver the 2022/23 financial plan of the ICS.

Key issues are:

- The delivery of efficiency and productivity plans.
- Elective System Recovery Funding: the system plan is underpinned by full receipt of Elective Recovery Funds (ERF) income. Quarter 1 has proved challenging for providers and ERF plans are not currently being delivered.
- Inflationary pressures over funding levels.
- The impact of the pay settlement for NHS staff not being fully funded.

Mitigations are being developed to manage these issues.

Have you recorded the risk/s on the Risk Management system?	Yes ☐	No ☒

The risks have been identified and are in the process of being transferred to the risk management system.

Are there any financial implications or other resourcing implications?

The paper presents the financial position of the BLMK ICB and intra system NHS partners.

How will / does this work help to address the Green Plan Commitments? Click to view Green Plan
Not Applicable.
How will / does this work help to address inequalities?
The finance plan reflects operational plans that include a focus on addressing inequalities.
The following individuals were consulted and involved in the development of this report:
BLMK Directors of Finance
Next steps:
Not Applicable.
Appendices
There are none.

1.0 Introduction

1.1 The purpose of this paper is to report the Integrated Care System (ICS) financial position at month 4 (July) for those NHS organisations that form part of the Bedfordshire, Luton and Milton Keynes (BLMK) ICS financial control total. These organisations are:

- Bedfordshire Luton and Milton Keynes Integrated Care Board
- Bedfordshire Hospital NHS Foundation Trust
- Milton Keynes University Hospitals NHS Foundation Trust

1.2 The paper sets out income and expenditure performance, capital, efficiency plans, and key financial risks.

1.3 The aim is to expand reporting over time to incorporate the financial position of other system partners, including social care.

2.0 System Income & Expenditure Position

2.1 NHS organisations that form part of the BLMK ICS financial control total have individually and collectively set financial plans that aim to deliver breakeven financial positions for the 2022/23 financial year. The table below shows the position for intra-ICS NHS organisations.

Surplus / (Deficit)	Year-to-date				Forecast Outturn (Full year)			
	Plan	Actual	Variance		Plan	FOT	Variance	
	£m	£m	£m	%	£m	£m	£m	%
Bedfordshire Hospital NHS FT	0.0	0.0	0.0	0.0%	0.0	0.0	0.0	0.0%
Milton Keynes NHS FT	(3.9)	(5.5)	(1.6)	41.0%	0.0	0.0	0.0	0.0%
BLMK CCG/ICB	0.0	0.0	0.0	0.0%	0.0	0.0	0.0	0.0%
Intra ICS Organisations	**(3.9)**	**(5.5)**	**(1.6)**	**0.0%**	**0.0**	**0.0**	**0.0**	**0.0%**

2.2 The ICS is reporting a year-to-date deficit of £1.6m and forecasting breakeven by the end of the year.

2.3 Bedfordshire Hospitals NHS Foundation Trust (BHFT) and the Integrated Care Board are reporting delivery of year-to-date and forecast plans. Milton Keynes University Hospital NHS Foundation Trust (MKUFT) is reporting a £1.6m year-to-date deficit but is forecast to breakeven by the end of the year. The MKUFT year-to-date deficit position reflects concern regarding elective performance and the potential risk of clawback of Elective Recovery Funding where activity volumes have not met operational plans. Excluding this adjustment, the ICS financial position would be break-even at month 4.

2.4 Financial performance commentary for each intra-ICS organisation is set out below:

2.5 **Bedfordshire Hospital NHS Foundation Trust**

A summary financial position at month 4 for Bedfordshire Hospital NHS Foundation Trust is set out in the table below:

Income & Expenditure	Year-to-Date			Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Income	233,572	235,694	2,122	700,757	699,886	(871)
Agency Pay	(7,136)	(8,683)	(1,547)	(21,412)	(21,412)	0
Other pay	(143,648)	(143,685)	(37)	(430,926)	(430,926)	0
Non Pay	(82,800)	(83,245)	(445)	(248,419)	(247,548)	871
Of which - non operating items	*(3,217)*	*(2,856)*	*361*	*(9,639)*	*(8,768)*	*871*
Surplus/(Deficit)	**(12)**	**81**	**93**	**0**	**(0)**	**(0)**

The key drivers for the year-to-date variances are:

- Income – ahead of plan but forecast to head towards plan by the end of the year.
- Pay – Higher levels of bank and agency, particularly on medics driven by high levels of emergency activity, covid staff sickness and elective recovery.
- Non-Pay – High levels of drugs spend.

2.6 **Milton Keynes University NHS Foundation Trust**

The summary financial position for Milton Keynes University NHS Foundation Trust at month 4 is set out in the table below:

Income & Expenditure	Year-to-Date			Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Income	107,481	106,261	(1,220)	326,996	326,996	(0)
Agency Pay	(2,323)	(4,239)	(1,916)	(5,602)	(5,602)	0
Other Pay	(68,865)	(67,326)	1,539	(202,605)	(202,605)	0
Non Pay	(40,176)	(40,175)	1	(118,789)	(118,789)	0
Of which - non operating items	(1,922)	(1,783)	139	(5,767)	(5,607)	160
Surplus/(Deficit)	**(3,883)**	**(5,479)**	**(1,596)**	**0**	**0**	**(0)**

The key drivers for the variances are:

- Income – this is adverse to plan principally because of recognising only the 25% “floor” of Elective Recovery Fund income due to elective activity being lower than the Elective Recovery Fund targets.
- Pay costs are over plan due to higher levels of bank and agency to mitigate the operational impact of higher than planned sickness and vacancy rates.
- Non-Pay – costs are broadly in line with the financial plan

2.7 **Integrated Care Board**

Clinical Commissioning Groups (CCG) remained as statutory organisations between 1 April 2022 to 30 June 2022. The full year 2022/23 Integrated Care Board allocation has been reduced by the resources consumed by Bedfordshire, Luton and Milton Keynes CCG in the first three months of the year. Therefore, at the point of establishment, the ICB received the remaining funding for the balance of the financial year.

At the end of quarter 1 there was a surplus of £9.3m in BLMK CCG. CCG allocations were adjusted by NHSE to bring all CCGs to breakeven and any surplus or deficit compared to the quarter 1 allocation was rolled forward into the new ICB. The difference of £9.3m has been carried forward into the ICB allocation for the remainder of the year.

The table below shows ICB performance against key financial performance indicators. At month 4 the ICB is delivering and forecasting full achievement of these metrics.

Performance Measure	Year To Date - Month 4			Forecast		
	Target	Actual	Variance	Target	Actual	Variance
Revenue Resource Limit	£573.2m	£573.2m	£0.0m	£1,768.4m	£1,768.4m	£0.0m
Capital Resource Limit	£0.0m	£0.0m	£0.0m	£0.0m	£0.0m	£0.0m
MHIS	£13.0m	£13.0m	£0.0m	£156.1m	£156.1m	£0.0m
Efficiency Savings	£5.6m	£5.6m	£0.0m	£15.4m	£15.4m	£0.0m
BPPC	>95%	100%	5.0%	>95%	95%	0.0%

The ICB is reporting a breakeven YTD against a planned breakeven position and is forecasting a breakeven financial position. The position by commissioning programme as at month 4 is set out in the table below:

PROGRAMME AREA	YEAR TO DATE - MONTH 04				FORECAST OUTTURN			
	Budget £000	Actual £000	Variance £000	Variance %	Budget £000	Forecast £000	Variance £000	Variance %
Acute Services	84,059	83,999	60	0.1%	722,245	722,011	234	0.0%
Mental Health Services	15,568	16,041	(473)	(3.0%)	142,488	142,898	(410)	(0.3%)
Better Care Fund	2,538	2,573	(35)	(1.4%)	23,070	23,106	(35)	(0.2%)
Other Community Services	11,412	11,873	(461)	(4.0%)	103,644	105,782	(2,137)	(2.1%)
Continuing Care Services	5,537	6,340	(803)	(14.5%)	54,750	57,011	(2,261)	(4.1%)
Primary Care Co-Commissioning	15,887	15,887	0	0.0%	122,418	122,418	0	0.0%
Prescribing	12,133	13,486	(1,353)	(11.2%)	104,241	105,263	(1,022)	(1.0%)
Other Primary Care Services	2,790	2,795	(6)	(0.2%)	25,614	27,091	(1,477)	(5.8%)
Other Programme Services	871	1,311	(441)	(50.6%)	11,417	12,047	(630)	(5.5%)
Reserves	3,573	282	3,291	92.1%	26,426	19,653	6,773	25.6%
Total Commissioning	**154,367**	**154,588**	**(220)**	**(0.1%)**	**1,336,313**	**1,337,280**	**(967)**	**(0.1%)**
Running Costs	**1,533**	**1,313**	**220**	**14.4%**	**14,710**	**13,743**	**967**	**6.6%**
Planned Surplus/(Deficit)	**0**	**0**	**0**	**0.0%**	**0**	**0**	**0**	**0.0%**
Total ICB Allocation	**155,900**	**155,900**	**0**	**0.0%**	**1,351,023**	**1,351,023**	**0**	**0.0%**

The key variances from budget are highlighted below:

Mental Health is £473k year-to-date overspend with a year-end forecast of £410k overspend. This is mainly driven by an increase in non-contracted activity referrals and new Section 117 (s117) clients.

There is continuing collaborative work around the Bedfordshire s117 workstream to deliver efficiencies and ensure timely reviews.

The MHIS target for the year is expected to be achieved. However, it should be noted that the challenging level of s117 efficiencies need to be met to ensure recurrent MHIS commitment is within the ICB allocation.

Other Community Services is over-spent by £461k year-to-date with a year-end forecast of £2,137k overspend. The variance primarily reflects the continuation of discharge to assess processes following the end of Hospital Discharge Programme and an increase in costs above 2021/22 activity levels due to earlier discharge from hospital.

Continuing Care Services is reporting a £803k year-to-date overspend with a year-end forecast of £2,261k.

Adult CHC is reporting a year-to-date overspend of £960k driven by an increase in CHC activity and costs - including the impact of inflationary pressures. Further work is underway to assess the risks to the plan and available mitigations.

Prescribing – this is an area where estimation is required due to the timing of data flows. Information is provided two-months in arrears and there can be some volatility in the cost of medicines due to national and international supply issues.

At month 4 the ICB reports a £1,353 year-to-date overspend and a forecast of £1,022k overspend. The overspend arises from an unexpected increase in May expenditure due to the volumes of prescriptions scripts issued. Further work is underway to assess the risks to the plan and available mitigations.

Reserves – The under spend of ICB reserves reflects the release of reserves offset cost pressures in other commissioning budgets as referred to above, £1.5m and the release of reassessed prior year accruals that have been identified as being previously overestimated.

3.0 System Efficiency Plans

3.1 The system financial strategy includes delivery of an efficiency plan of £55.6m.

3.2 The ICS is reporting savings of £12.3m year to date, £3.6m below plan. The forecast remains to deliver the full plan of £55.6m by the end of the year.

	Recurrent/ Non Recurrent	Year To Date				Forecast			
		Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %
ICB	Recurrent	2,409	2,409	0	0%	8,214	8,214	0	0%
	Non Recurrent	2,270	2,270	0	0%	7,227	7,227	0	0%
Subtotal		**4,679**	**4,679**	**0**	0%	**15,441**	**15,441**	**0**	0%
BHFT	Recurrent	7,986	4,324	(3,662)	-46%	23,951	23,951	0	0%
	Non Recurrent	1,400	1,444	44	3%	4,200	4,200	0	0%
Subtotal		**9,386**	**5,768**	**(3,618)**	-39%	**28,151**	**28,151**	**0**	0%
MKFT	Recurrent	1,450	1,450	0	0%	9,049	9,049	0	0%
	Non Recurrent	400	400	0	0%	3,000	3,000	0	0%
Subtotal		**1,850**	**1,850**	**0**	0%	**12,049**	**12,049**	**0**	0%
Total Efficiencies		**15,915**	**12,297**	**(3,618)**	**-23%**	**55,641**	**55,641**	**0**	0%

3.3 Bedfordshire Hospitals Foundation Trusts report a £3.6m under delivery versus plan, with slippage against several schemes. The Trust remains confident that this can be recovered and/or mitigated and that the efficiency plan will be delivered in full by year-end.

3.4 In-year plans include non-recurrent elements, 26% of the total - this is a potential issue for the system going into future financial years and will form part of the work being undertaking to refresh the medium term financial strategy of the system.

4.0 System Financial Risks

4.1 The system financial plan set out several risks to plans which are under constant review. Mitigations to offset these risks and other emerging risks are being developed. The current risks are set out below:

Risk Title	Risk Description	Risk Control	Action Required
Delivery of Efficiency Programme	As a result of the efficiency plan not being delivered there is a risk that the ICS will not breakeven at the end of 2022/23	Regular meetings with scheme leads to update on progress and ability to stretch, plus any actions required if deviations from plan identified Presented to Performance & Delivery Group and to Finance & Investment Committee	Ongoing monitoring and early escalation of any scheme deviating from plan Continued scanning for further opportunities to add to plan to mitigate any shortfalls
Increase in operational and winter pressures	As a result of an increase in operational pressures and winter pressures, there is a risk that additional costs will be incurred that cannot be met from existing resources, resulting in the ICS not breaking even at the end of 2022/23.	Signed contracts in place for all services. Engagement with local authority partners via s75 / BCFs agreed System capacity to enable appropriate discharge to and from step down beds	All contracts to be agreed and signed for acute, 999 and Out of Hours /111 services Prescribing forecast and profile to be understood to identify level of operational pressure ABI / Stroke and s117 budget pressures to be monitored
Elective Recovery Fund (ERF)	As a result of activity below target in H2, there is a risk that ERF will be clawed back after costs have been incurred to deliver activity.		Acute activity to be monitored monthly and impact of ERF modelled
Inflation	As a result of inflation being higher than funded via tariff and allocations, there is a risk that providers will face additional costs that they cannot manage.		Monthly monitoring of spend against budget Review of non-recurrent opportunities within 2022/23 available to mitigate inflation
Management / Running Costs	As a result of the pay award being higher than budgeted, and unfunded, which is a real terms cut in Running Costs, there is a risk of a reduction in ICB staffing and capacity to support establishing the new organisation and ways of working,	Vacancy control process NHSE business case completed for interim staff and consultancy spend	Pay award to be modelled and impact understood on each budget Agree approach to managing individual budget pressures with Executive budget holder
Covid	As a result of a new variant of covid or an increase in infections and hospitalisations, costs may increase whilst the covid allocation that was issued to cover these additional costs, has reduced	Reporting of spend against covid allocation monthly to identify early any pressures on funding	Monitoring of covid expenditure within ICB and across ICS

5.0 System Capital

5.1 BLMK ICS has a capital departmental expenditure limit (CDEL) which it cannot breach. This limit applies to those organisations which form part of the BLMK ICS financial control total. Currently capital for East London NHS Foundation Trust (ELFT), Central and North West London NHS Foundation Trust (CNWL) and Cambridgeshire Community Services (CCS), who provide community and mental health services in Bedfordshire, Luton and Milton Keynes, is held within their lead systems.

5.2 ICS organisations may also receive other capital funding from ringfenced national sources to support key priorities including the Government's New Hospitals Programme and capital to support elective recovery, digital, community diagnostics etc…

5.3 The table below shows the year-to-date and forecast financial performance of intra system providers against CDEL and other capital funding sources. The system annual CDEL is £43.3m and at month 4 providers are forecasting that they will deliver a break-even position against this limit. The ICB does not have a CDEL limit.

Capital Plan	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Annual £'000	Actual Forecast £'000	Variance Forecast £'000
Charge against capital allocation (CDEL)	10,041	15,509	(5,468)	43,341	43,341	0
Other capital funding streams	12,141	6,010	6,131	95,937	95,800	137
Total	**22,182**	**21,519**	**663**	**139,278**	**139,141**	**137**

5.4 The ICS is expecting an increase to the CDEL limit to offset the impact of the implementation of financial reporting standard IFRS 16. New leases or modifications of existing leases from 1 April 2022 will count against the capital departmental expenditure limit (CDEL) and limits will need to be increased to manage the impact of the implementation of the new standard.

5.5 The table below shows the year-to-date and forecast position for the intra-ICS NHS organisations across all capital funding streams. There is a small underspend of £0.7m forecast across the intra-ICS organisations.

Capital Expenditure	Year-to-date				Forecast Outturn			
	Plan	Actual	Variance		Plan	Forecast	Variance	
	£m	£m	£m	%	£m	£m	£m	%
Bedfordshire Hospital NHS FT	19.5	18.9	0.7	3.6%	115.8	115.8	0.0	0.0%
Milton Keynes NHS FT	2.7	2.7	0.0	0.0%	23.5	23.3	0.1	0.4%
BLMK ICB	0.0	0.0	0.0	0.0%	1.6	1.6	0.0	0.0%
Intra ICS Organisations	**22.2**	**21.6**	**0.7**	**3.2%**	**140.9**	**140.7**	**0.1**	**0.1%**
CNWL								
ELFT	1.6	1.2	0.3	21.4%	4.7	4.7	0.0	0.0%
CCS	0.5	0.7	(0.2)	0.0%	5.5	5.5	0.0	0.0%
Inter ICS Organisations	**2.1**	**1.9**	**0.1**	**7.1%**	**10.2**	**10.2**	**0.0**	**0.0%**

- Bedfordshire Hospitals is reporting a slight underspend year-to-date but forecast breakeven against their capital plan. Performance against CDEL limit is forecast to breakeven.
- Milton Keynes Hospital is reporting a year-to-date breakeven position but forecasting this will become a small underspend of £0.1m by the end of the year and relates to donated capital, which is excluded from CDEL. Performance against CDEL limit is forecast to breakeven.
- The ICB has been notionally allocated capital funding of £1.66m to support GP IT and corporate capital. Our capital plans are currently going through an internal prioritisation process. The Integrated Care Board is reporting no spend year to date but forecasts to spend this allocation in full. Capital expenditure on GP IT is capitalised by NHS England rather than the Integrated

Care Board. All ICB capital is therefore subject to NHS England business case processes and only released when business cases are approved.

6.0 Recommendations

6.1 The Integrated Care Board is asked to:

- Note the year-to-date financial position of the ICS at month 4 and forecast position for revenue and capital
- Note the risks to the financial forecast

Glossary of commonly used terms in Finance reports

Acronym	Name	Description
BHFT	Bedfordshire Hospitals NHS Foundation Trust	
CCS	Cambridge Community Services NHS Trust	Provides community services in Luton and Bedfordshire
CDEL	Capital Department Expenditure Limit	Each department of Her Majesty's Treasury (HMT) has a departmental expenditure limit (DEL) which can be separated into capital and revenue DEL. The government controls overall expenditure by deciding each department's DEL. The Department of Health and Social Care (DHSC) sets a capital departmental expenditure limit (CDEL), which covers the capital spend of NHS trusts and is used by DHSC and HMT to monitor and manage capital expenditure within the sector.
CNWL	Central and North West London NHS Foundation Trust	Provides Community and Mental Health Services in Milton Keynes.
ELFT	East London NHS Foundation Trust	Provides Community and Mental Health Services in Bedfordshire and Luton.
ERF	Elective Recovery Funds	The ERF is designed to support systems to work collaboratively to restore elective services against the backdrop of unprecedented demands on the service because of Covid. It ensures that the marginal costs of delivering extra activity to tackle a lengthening waiting list can be met.
H1 or H2	Half Year	H1: Covers April-September H2: Covers October-March
HDP	Hospital Discharge Programme	Details the discharge requirements for all NHS trusts, community interest companies, private care providers of acute, community beds and community health services and social care staff in England. The guidance, based on successful discharge to assess principles, aims to ensure that all individuals are discharged from hospital in a safe, appropriate and timely way. Funding was provided by NHS England to support HDP in 2020/21 and 2021/22
ICS	Integrated Care System	ICSs are partnerships between the organisations that meet the health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.
MHIS	Mental Health Investment Standard	MHIS is the requirement for ICBs to increase investment in Mental Health services in line with their overall increase in allocation each year.
MKUHFT	Milton Keynes University Hospital NHS Foundation Trust	
NHSE	NHS England	
SDF	System Development Funds	Resource allocations for specific programme activities deemed a priority by NHSE for 2022/23.
YTD	Year-To-Date	

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
13. Planning for Winter 2022 to 2023

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☐	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☒	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☒	Ways of working ☒	Estates ☐
Communications ☐	Finance ☐	Operational and Clinical Excellence ☒	Governance and Compliance ☒
Other ☐ (please advise):			

What are the members being asked to do?		
Approve ☐	Note ☒	Discuss ☐

Report Author	Jan Wood Associate Director of Individualised Care and System Flow Richard Alsop Interim Chief Transformation Officer
Date to which the information this report is based on was accurate	21st September 2022

Senior Responsible Owner	Geraint Davies, Director of Performance and Governance

Executive summary

Each year, health and care systems come together to plan for the coming winter. These plans are informed by learning from previous winters and intelligence as to likely demand for services across the winter period.

This paper provides the Board with an update on the planning process being undertaken by partners across BLMK for winter 2022/23.

The ICB's Flow team is co-ordinating development of the plan, working with partners across the system.

We have RAG rated our system performance across 11 domains. As of 16th September, 55% of these domains we have assessed as being fully implemented, and compliant with best practice, whilst 41% are partially implemented, so are not yet fully compliant, and the remaining 4% either not relevant or awaiting further guidance. The percentage of non-compliant domain work is and will continue to be the focus for improvement work.

The Winter Plan is scrutinised and approved by the Performance & Delivery Group.

What are the available options?

Not Applicable

Recommendation/s

The members are asked to **note** the following:

1) Note the programme of work underway to prepare for what will be an extremely challenging winter period.
2) Note the additional capacity and alternative pathways being put in place to address expected demand for acute care in particular.
3) Note the assurance process in place through the Performance & Delivery Group and determine what information the Board would wish to see regarding system performance over the coming months.

Key Risks and Issues

1. As a result of winter demands outstripping planned capacity, there is a risk that there may be delays in patients receiving some types of care, with the effect that they may be more unwell when treated. BLMK has drawn up heightened pressure capacity plans in addition to *in extremis* mitigations, to be enacted in the event of super surge.
2. As a result of pressures on social care that cannot be met, there is a risk that patients will not be able to move in their onward care journey, resulting in delays in either acute beds or more likely, intermediate services creating greater community caseloads and the need for spot purchasing of health beds and services. This is itself limited by the community and independent capacity and safe staffing.
3. As a result of workforce pressures, there is a risk that gaps in staffing will limit the ability to turn-on new capacity as planned, in particular escalation areas and virtual wards. The BLMK workforce group owns this risk.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐

IC 1
IC 25

Are there any financial implications or other resourcing implications?

Whilst we do have access to Section 256 monies, the need for spot purchasing will create additional pressures.

How will / does this work help to address the Green Plan Commitments? Click to view Green Plan

Not Applicable

How will / does this work help to address inequalities?

Not Applicable

The following individuals were consulted and involved in the development of this report:

Alison Blair (BCA)	Christopher Carberry (EEAST)	Georgie Browne (NHSE)	John Blakesley (MKUHFT)
Anita Pisani (CCS)	Daphne Thomas (MKUHFT)	Geraint Davies (BLMK ICB)	John Culley (CNWL)
Anne Murray (BLMK ICB)	Carol Davies (BLMK ICB)	Hilary Tovey (BLMK ICB)	John Molyneux (BBC)
Cathy Jones (BHFT)	Penny Emerson (BLMK ICB)	Jackie Dunn (CNWL)	John Syson (BLMK ICB)
Edwin Ndlovu (ELFT)	Emma Livesley (MKUHFT)	Jane Hannon (CNWL)	Allison Jones (ELFT)
Kate Corlett (ELFT)	Kate Vaughn (EEAST)	Bruce Luter (CCS)	Maria Wogan (BLMK ICB)
Mark Begley (SCAS)	Mark Harris (BBC)	Mark Meekins (BLMK ICB)	Matt Hollex (BLMK ICB)
Melanie Wilson (CNWL)	Michael Harrington (EEAST)	Michael McGhee (ELFT)	Michael Ramsden (BLMK ICB)
Michelle Bradley (ELFT)	Nicky Poulain (BLMK ICB)	Neve Patel (BLMK ICB)	Patricia Coker (CBC)
Paul Burridge (BLMK ICB)	Paul Kerr (NHSE)	Richard Fradgley (ELFT)	Martha Roberts (BLMK ICB)
Sarah Browne (HCT)	Simon King (EEAST)	Simon White (BBC)	Stephen Makin (BLMK ICB)
Steve Winfield (SCAS)	David Stout (MKCA)	Tim Hughes (BHFT)	Nicky Wadeley (BLMK ICB)
Charles Wheatcroft (BLMK ICB)			

Next steps:

As reflected under section 3

Appendices

Appendix A – Example Performance & Delivery Performance Report

1. Introduction

Each year, health and care systems come together to plan for the coming winter. These plans are informed by learning from previous winters and intelligence as to likely demand for services across the winter period.

This paper provides the Board with an update on the planning process being undertaken by partners across BLMK for winter 2022/23.

The ICB's Flow team is co-ordinating development of the plan, working with partners across the system.

We have RAG rated our system performance across 11 domains. As of 16th September, 55% of these domains we have assessed as being fully implemented, and compliant with best practice, whilst 41% are partially implemented, so are not yet fully compliant, and the remaining 4% either not relevant or awaiting further guidance. The percentage of non-compliant domain work is and will continue to be the focus for improvement work.

The Winter Plan is scrutinised and approved by the Performance & Delivery Group.

2. Background

Demand for care across all sectors is currently extremely and unusually high and all indicators are that this will only grow over winter. In the southern hemisphere, incidence of Influenza has been high this year, and it usually follows that this is mirrored in the northern hemisphere's winter. Covid remains present in the community, and we need to plan for further peaks in demand on our services across the winter period.

Elective services must be maintained, and further inroads made into clearing the backlog of people waiting for their operations. This is extremely challenging for acute hospitals who need to balance the need to maintain elective work whilst managing increased emergency admissions. This pressure is reflected in all community-based services, with burgeoning caseloads and higher levels of acuity requiring management and care.

We need to plan for additional capacity to be put in place to manage the likely demand for services and make the best use of the capacity we already have. Partners in BLMK have come together to already look to see what additional capacity can reasonably be commissioned, given the constrictions of workforce and available estate. Working with NHS England we have secured funding for the following:

- Virtual Wards: 230 beds by Dec 2022
- A Demand & Capacity submission: additional equivalent acute capacity of 77 beds

However, we need to ensure that flow through our system is maintained, and that all avoidable admissions are signposted to alternative services.

There are significant challenges in areas such as a lack of intermediate and long-term domiciliary care in some areas that act as a barrier to rapid discharge, leading to people staying in hospital or community beds for longer than is necessary, which can compromise their long-term health and independence.

A plan to provide additional capacity and make improvements to patient flow across the system is in development and will be signed off by senior leaders by 23rd September. This will then be submitted to NHS England.

3. Developing the Plan

Winter Planning is perennial, and this year, given the heightened demands that all areas are experiencing, the ICB was asked to coordinate, on behalf of all stakeholders, an Urgent & Emergency

Care, UEC, Assurance Framework. It consists of many tabs concerned with specific domains, such as Ambulances, Mental Health, Flow, Primary Care, etc., with responses required for specific actions. It also requested more information on the additional Demand & Capacity funded schemes (mentioned above) intended to deliver increased acute capacity.

The timescales for completion and submission of the Assurance Framework and Demand & Capacity document are below:

Date	Task
15th August 2022	UEC Assurance Framework issued to P&D Group
15th – 19th August 2022	ICB colleagues to complete initial KLOE submissions against the Service Improvement tabs
18th August 2022	Discussion at P&D Group regarding process and requirement
22nd – 25th August 2022	ICB/sub-system/providers leads review and revise pre populated KLOEs
25th August 2022	Revised KLOEs submitted to ICB to edited into master file
26th August 2022	Revised draft issued to P&D Group members for virtual sign off
30th August 2022	Final comments received from P&D Group members and UEC Assurance Framework revised accordingly
31st August 2022	Final draft UEC Assurance Framework shared with TILT for approval at 12 noon
31st August 2022	Approved UEC Assurance Framework submitted to NHSE by cop for initial review and feedback
1st September 2022	Winter Plan reviewed at P&D Group in the light of the UEC Assurance Framework and identified gaps
1st – 15th September 2022	ICB/sub-system/provider leads agree actions to address identified gaps
16th September 2022	Agreed actions to address gaps are submitted to ICB to collate into draft Winter Plan 2022/23
16th – 20th September 2022	Draft Winter Plan issued to system partners for final review and comment
26th – 28th September 2022	Finalised Draft Winter Plan circulated to system partners for final review
29th September 2022	Finalised Winter Plan reviewed and signed off on behalf of the system at the P&D Group
30th September 2022	Winter Plan 2022/23 issued to system partners and NHSE

A suite of workshops, small group conversations and the completion of the UEC Assurance Framework are key elements of planning for winter. Whilst coordination is performed by the ICB's Flow team, each stakeholder is responsible for contributing its own part of the whole.

BLMK submitted its Demand & Capacity Plan and draft Version 1 of the Assurance Framework by 31st August, having been scrutinised and agreed by the Performance & Delivery Group prior to submission. The submission included a self-assessment against 11 domains.

The table below shows the BLMK current self-assessment against the relevant domains, showing that 55% of Key Lines of Enquiry, KLOEs are fully compliant, with the remainder to be the subject of our system improvement plans.

Assurance Framework Domain	Number of KLOES in section	Fully Implemented		Partially Implemented		Planned to be Implemented		Not deemed relevant		Querying with NHSE	
		No	%	No	%	No	%	No	%	No	%
Integrated Urgent Care	4	3	75%	1	25%						
Ambulance	8	3	38%	5	63%						
High Intensity Users	3	2	67%	1	33%						
Alternative Acute & Community Pathways	9	3	33%	5	56%	1	11%				
Emergency Department	16	6	38%	9	56%					1	6%
Treatment in the Emergency Department	13	12	92%	1	8%						
Staffing	8	6	75%	2	25%						
Urgent Treatment Centres	5	1	20%	2	40%						
Flow	6	4	67%	2	33%			2	33%		
Mental Health	9	4	44%	5	56%						
Operational Management & Escalation	5	4	80%	1	20%						
Integrated Care Board	7	3	43%	4	57%						
Totals	**93**	51	55%	38	41%	1	1%	2	2%	1	1%

Feedback from NHSE EoE has been very positive, to the extent that we are not required to produce a separate winter plan or narrative.

Version 2 is in production currently, as final details and small elements of clarification with providers and other stakeholders are applied. The final version will be approved by the Performance and Delivery Group before submission to meet the end of September deadline.

4. Important Aspects of the 2022/23 Winter Plan

The following are important aspects of our planning for the coming winter. Briefly they are;

4.1 Primary Care access

The ICB is actively engaging and supporting with seasonal preparedness and operational delivery. There is a separate system framework to be completed for Primary Care concerned with prioritisation of practical interventions to improve patient experience of access and staff workload locally. Further there is need to engage in the national process to secure potential funding for technology/estates solutions, whilst moving to Cloud-based technologies, starting with telephony.

Given the demands and constraints in primary care, Primary Care Networks, PCNs, are working with each other and other providers to develop collaborative models to manage specific winter pressures (for example oximetry monitoring for COVID; winter hubs; community and VCS led support for vulnerable)

There is an active ICB-led programme of hands-on quality improvement support to practices working in the most challenging circumstances (including areas of high deprivation, areas with highest need or workforce challenges) via the national ‘Accelerate’ support programme available to 400 practices for 22/23 alongside addressing barriers outside the scope of the support. To date 14 practices have had some level of engagement with the programme.

The MiDoS tool will be developed to widen the content of health, social care and voluntary sector services to enable professionals to direct patients to the right pathways and services.

More Business Intelligence tools will be rolled out to General Practice that will help with the understanding of demand and capacity. Support and training will go alongside the rollout to maximise the opportunity for improvements.

Expansion of the Community Pharmacy services is intended to divert demand away from general practice into community pharmacies aligned to metrics outlined in the Primary Care Investment and Impact Fund. There is also a Discharge Medicines Service to community pharmacies to help prevent readmissions to hospital.

4.2 Virtual wards - maximising the opportunity based on funding provided

BLMK has two major programmes of VW work, managed within each of the two subsystems and coordinated at ICB level. Both subsystem plans vary from other ICS plans in that we are maximising acute admission avoidance management, particularly for those with respiratory and/or frailty.

Plans intend that we will have approx. 230 virtual beds by December 2022.

4.3 Mental health alternatives to ED

BLMK mental health and well-being staff - Keeping Well BLMK Hub - is available to staff across Bedfordshire, Luton and Milton Keynes. The Keeping Well BLMK Hub has several access points where staff can access support such as through a telephone line, through a call back system and a 'chat' function on the website. The Hub has been promoting the service through several channels including social media.

The Mental Health Perfect week identified further opportunities and work is currently under way with BLMK Mind, Mental Health services and commissioners and the ICB Communications team.

4.4 Ready to proceed – (the North Bristol Model)

The North Bristol Model is a process for maximising flow away from the ED to create capacity for offloading ambulances without delay. The basic elements of it are:

- Early discharge before midday. (For patients who do not require any package of care or assessment)
- Ambulances must not queue for longer than 120 minutes at acute wards in any circumstance
- Three admitted patients will be moved from the emergency department every two hours to acute wards, i.e., Boarding, irrespective of bed availability.
- Selected side-room double occupancy where safe to do so

BLMK already has some elements of that in place, particularly the double bedding of some side-rooms or bays. Further work is underway to assess the capability to move more towards the model, or to identify alternatives and/or constraints.

It’s important to note the Bedford and Milton Keynes Hospital sites have been recognised nationally as the 2 top performing Acutes the region for minimising handover delays.

4.5 Gold Standard Falls Service

BLMK stakeholders have agreed the standard for Falls services and are in the processing of commissioning services to address the remaining gaps.

In addition, work with Ambulance and Community Trusts to adopt falls 'pick-up' services is nearing completion, with Go live imminent.

4.6 Integrating 62-day standard into Elective Recovery Monitoring

BLMK has an agreed and clear trajectory for meeting the requirement and its anticipated position to March 2023. This is due to excellent whole system working and commitment to the ask, and we are confident of delivery.

Improvement plans are in place and have been approved by the Chief Executive Officers of both acute Trusts along with the system's Cancer SRO. The Cancer Board is accountable for ensuring these plans are delivered with regular oversight in fortnightly Cancer Recovery Meetings, which the Cancer Alliance attends. The Elective Leadership Group, which includes COOs, ICB directors and NHSEI Performance Directors also oversees delivery, unblocking barriers where necessary.

Alongside these plans, the system is fully engaged in the EoE Diagnostic Project which looks to investigate and identify diagnostic delays within cancer 62-day breaches. This provides intelligence that can support further improvements in cancer performance both locally and across the region.

Furthermore, system oversight takes place via the fortnightly Performance & Delivery Group (chaired by the ICB Director of Performance) and reported monthly to the Chief Executive Officers Meetings and the System Oversight and Assurance Group.

4.7 Targeted discharge interventions

Daily reviews either by clinical decision-makers (including board or ward round processes), 7 days per week, and introduction of Estimated Dates of Discharge, together with the SAFER bundle of interventions[1], and earlier in the day discharges, whilst actively manging intermediate capacity and service length of stays, will result in flow being improved. This will result not only in fewer delayed patients, but also will free beds and staff to minimise ambulance delays.

Multi-disciplinary Teams, MDTs, teams are in place 7 days a week as are MDT bed flow meetings. We strive to have robust escalation processes in place where all organisations will respond to an escalation call with minimal time frame (i.e. 30 mins). The PHEW application across Bedfordshire Trusts and Community beds supports real time management of flow and identifies at an early stage where delays are occurring. These delays are communicated to relevant stakeholders for resolution.

Criteria led discharge for medical patients is being piloted at the Bedford Hospital site.

4.8 Targeted interventions in care homes to reduce conveyances

There is a suite of work that includes:

[1] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high

- Regular MDTs taking place in care homes, resolving where they are not regularly being held. These are opportunities to address concerns about residents and ensure appropriate care and support planning
- Working with place-based community teams to ensure support and including remote monitoring accessibility
- Providing 'first response' support contacts that can be explored prior to calling for an ambulance: posters produced and circulated
- Ensuring Raizer chairs or equivalent are being used to support residents who have fallen
- Deployment of Whzan kits and use of NEWS2. These provide baselines that can be utilised by ambulance crews/first responders to assess need for conveyance
- Having PCN Care Home Co-ordinators and other PCN ARRS funded staff proactively checking in with homes to provide early interventions.
- The Complex Care team is now pan Bedfordshire

4.9 Ambulance and Community Services avoiding conveyances

BLMK is implementing access to the lower Category call stack, (Cats 3-5), to community services, to provide appropriate interventions, particularly by the 2 hour Urgent Community Response teams.

EEAST stack access is due to go live on 14 November. SCAS date is yet to be agreed.

BLMK is engaged with the Regional 999 to 111 project. This will see the transference of low acuity CAT 3,4 and 5 calls from the EEAST stack to a clinician in the 111 service for validation.

BLMK will be developing and enhancing the MiDoS tool that is already used by EEAST and SCAS, to increase conveyance to alternative services to A&E.

4.10 System control centre

NHSE has suggested that each ICS implements an 'enhanced system winter room', which is a clinically led 24/7 control centre with real time capacity and demand information managing patient flow across health and care. An output specification is being developed for every system.

BLMK ICS will assess the offer when received, to ensure it adds value to an already well managed and governed EPRR and UEC function

4.11 Alternative clinical models

The intention is that BLMK commissions sufficient and appropriate alternatives to ED attendance and hospital admission so that patients are treated in the most appropriate care setting according to their presented need: for example, increasing awareness of and access to pharmacists; the use of Same Day Emergency (or Urgent) units, particularly for those with frailty and or the older members of our population; the use of 'hot clinics' etc.

4.12 High Intensity Users - population segmentation work

High Intensity users are defined as those residents who have attended A&E 15 times or more in the previous 12 months, or have called or attended other emergency or urgent care services a significant number of times

BLMK has two sub-system services that provide proactive, non-medicalised support to those people identified. This involves a wide range of stakeholders, varying from police to voluntary organisations. Both services have achieved significant success in resolving many of the issues that result in HIU behaviours, frequently emanating from social or psycho-social causes, but manifesting in health demands. This work is closely related with our Personalisation and Population Health management functions.

4.13 Reviewing System Rules

Either real or perceived, i.e., 'pop-up', rules that need to be changed /challenged. For example, if a 111 call Ambulance CAT 3 or 4 disposition validation call back does not take place within 30 minutes then an ambulance is automatically dispatched; the need for a patient to have been discharged to a Discharge to Assess health bed and then to have an Occupational Therapy assessment before a social worker will accept referrals for a package of care.

Systems are asked to feedback examples of rules that could be changed to improve flow.

4.14 Respiratory hubs

We have an extensive programme to support the recovery and transformation for the population with Long Term Conditions. We have BLMK stakeholder groups for Diabetes, CVD and Respiratory. The respiratory group, working with Primary Care Networks and practices are developing the model for diagnostic respiratory hubs across BLMK. Currently 14 practices continue to offer diagnostic spirometry to their registered population; it is proposed to develop 13 further hubs.

5. Governance

Each of the two BLMK sub-systems have an operational group, the Delivery Group, and a Delivery Board formally constituted, and empowered to discuss and agree UEC matters.

Each sub-system has daily system wide calls at which the daily issues and performance are shared. From this, a daily situation report is created by the ICB Flow team and circulated widely.

For escalation, each sub-system has a protocol whereby additional calls, or more senior convened meetings ae called and attended.

The BLMK Performance and Delivery Group comprises senior members from all ICS stakeholder organisations. It has responsibility for the UEC agenda, its strategy and performance against key indicators, in addition to being the approver of UEC submissions and plans.

It has agreed a set of metrics that demonstrate grip of the system and early indication of variance. Performance is discussed at its bi-weekly meetings, in addition to a daily system dashboard being provide to members. An example report is appended at A.

6. Recommendations

The Board is invited to:

- Note the programme of work underway to prepare for what will be an extremely challenging winter period.
- Note the additional capacity and alternative pathways being put in place to address expected demand for acute care in particular.
- Note the assurance process in place through the Performance & Delivery Group and determine what information the Board would wish to see regarding system performance over the coming months.

Appendix A: Example Performance & Delivery Performance Report

100 Day KPI Update – last updated 14/9/22

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

104+ Week Waits
- As at end of July we saw a reduction from 9 to 5 patients waiting for treatment. 1 was at MKUH and the rest are outside of the BLMK system. **This is an improving position**.
- Local data up to 04/09/22 is showing BHFT **(improving position)** at 0 and MKUH **(improving position)** also at 0 patients, however there are 2 patients who could potentially breach in September but both have treatment dates next week.

78+ Week Waits
- As at end of July we saw a reduction from 491 to 462 patients waiting for treatment – 147 are outside of the BLMK system. **This is an improving position**.
- Local data up to 04/09/22 is showing a **deteriorating position** at both acute trusts with 368 people waiting 78+ weeks at BHFT against a plan of 259 and 50 at MKUH against a plan of 22.

Cancer Long Waiters – 63+ days after an urgent suspected cancer referral
Local data up to 04/09/22 is showing BHFT **(improving position)** at 368 which is a decrease on 371 previous week but is over the plan of 299 and 170 at MKUH **(improving position)** which is a decrease against the 171 previous week but remains above the plan of 157.

Ambulance Handovers – 7 day average – week ending 11/09/22
- 15 minute delays - is showing a **deteriorating position** for both providers. BHFT 80 against 68 previous week and MKUH 34 against 32 previous week.
- 30 minute delays – is showing a **deteriorating position** for both providers. BHFT 18 compared to 15 in previous week and MKUH 9 compared to 7 in previous week.

System Flow – Patients Discharged (No criteria to reside)
- 7 day average for week ending 11/09/22 at BHFT was 44.66% (average of 109 discharges out of 240 patients) against the national ambition of >50% and this is a **improvement** on the previous week at 40.24%.
- 7 day average for week ending 11/09/22 at MKUH was 37.76% (average of 52 discharges out of 134 patients) and this is an **improvement** on the previous week 32.64%.
- Note: previous week ending 04/09/22 is previously unreported due to data quality issues with the Discharge Sitrep Dashboard

System Flow - Bed Occupancy (total open beds)
- 7 day average for week ending 11/09/22 is showing an **improved position** at both Trusts.
- BHFT – 93.03% which is better than their plan for September of 93.8%
- MKUH – 92.06% which is better than their plan of 95.6%

System Flow - Beds Occupied with patients with a length of stay of 21+ days
- 7 day average for week ending 11/09/22 is showing a **deterioration** at BHFT with 16.41% compared to 15.97% in the previous week and against the national ambiti <15%.
- MKUH is showing an **improved position** with 21.5% compared to 22.45% in the previous week.
- Note: previous week ending 04/09/22 is previously unreported due to data quality issues with the Discharge Sitrep Dashboard

100 Day Challenge - Key Performance Indicators – Representative of System Pressures

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

	Ambition	Polarity	Latest Data	ICB		BHFT - Trustwide		MKUH - Trustwide		Out of S
RTT - Number of patients waiting 104+ Weeks (national data)	BHFT - 0 MKUH - 0	Low is good	Jul-22	5	⇧	0	⇔	1	⇩	4
RTT - Number of patients waiting 104+ Weeks (local provider data)	0	Low is good	04-Sep			0	⇧	0	⇧	0
RTT - Number of patients waiting 78+ Weeks (national data)	BHFT - 349 MKUH - 43	Low is good	Jul-22	462	⇧	366	⇩	35	⇧	147
RTT - Number of patients waiting 78+ Weeks (local provider data)	BHFT - 259 MKUH - 22	Low is good	04-Sep			368	⇩	50	⇩	
Cancer - 63+ Day Backlog - see definition below *	BHFT - 299 MKUH - 157	Low is good	04-Sep			368	⇧	170	⇧	
Number of 15-minute ambulance handover delays		Low is good	11-Sep 7 day average			80	⇩	34	⇩	
Number of 30-minute ambulance handover delays		Low is good	11-Sep 7 day average			18	⇩	9	⇩	
% Patients With No Criteria to Reside who are discharged	≥50%	High is good	11-Sep 7 day average			44.66% 109 / 240	⇧	37.76% 52 / 134	⇧	
Bed Occupancy (Total Open G&A Beds)	BHFT - 93.8% MKUH - 95.6%	Low is good	11-Sep 7 day average			93.03%	⇧	92.06%	⇧	
% Beds occupied by Patients with LoS 21+ Days	≤15%	Low is good	11-Sep 7 day average			16.41%	⇩	21.50%	⇧	
% Beds occupied by Patients with LoS 21+ Days - Criteria to Reside	n/a	Low is good	11-Sep 7 day average			8.01%	⇩	12.66%	⇧	
% Beds occupied by Patients with LoS 21+ Days - No Criteria to Reside	n/a	Low is good	11-Sep 7 day average			8.40%	⇩	8.83%	⇧	

* Cancer - 63+ Day Backlog - the number of cancer 62 day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non-site specific symptoms

Key	Trend Arrows	Achievement RAG	
⇧	Improving		On Track
⇩	Deteriorating		Off Track
⇔	No change		

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
14. Local Maternity and Neonatal System Equity & Equality 5-Year Action Plan

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☒	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☒	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☐	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☒	Workforce ☒	Ways of working ☒	Estates ☐
Communications ☒	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☒
Other ☐ (please advise):			

What are the members being asked to do?		
Approve ☒	Note ☐	Discuss ☐

Report Author	Hema Sutton, Lead Commissioner / Local Maternity and Neonatal System Programme Manager
Date to which the information this report is based on was accurate	15th September 2022
Senior Responsible Owner	Anne Murray, Local Maternity and Neonatal System Senior Responsible Owner / BLMK Nursing Director - Programmes

Executive summary

A recent 'Mothers Babies Reducing Risk: through Audit and Confidential Enquires' across UK (MBRRACE-UK): report about maternal perinatal mortality still show considerable differences in outcomes for women and babies from Black, Asian, and Mixed ethnic groups and those living in the most deprived areas. Furthermore, the Covid-19 pandemic highlighted the urgency to prevent and manage ill health in those who experience the greatest health inequalities.

In September 2021, Equity and Equality: Guidance for local maternity systems was published in response to these findings with a clear ask of local maternity systems to create a five-year plan setting out how we will work in partnership across the system to improve equity in outcomes for women and babies and race equality for staff.

The following report summarises the plan including key actions that have taken place and will continue to address this essential work.

The Local Maternity Neonatal System will oversee the work and have accountability for delivery.

The report has been shared through the BLMK Health Inequalities Board.

What are the available options?

To approve the plan ahead of submission to NHS England.

Recommendation/s

The members are asked to **approve** the following:

- Submission of the full action plan to NHS England

Key Risks and Issues

Key to delivering our action plan is our maternity and neonatal workforce. Without a sustainable workforce, we will struggle to implement our interventions and therefore improve equity for women and babies and equality for our Black Asian and Mixed ethnic staff. Locally our workforce is under strain and there are plans in place at both Trusts Maternity and Neonatal services to improve the workforce position which encompass a range of initiatives aimed including recruitment and retention, return to practice, international recruitment and evolving the role of maternity support workers.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐

CYP12

Are there any financial implications or other resourcing implications?

Funding to implement is already available through the maternity transformation funding. In addition, we have received funding from the ICS Health Inequalities programme to support local initiatives.

How will / does this work help to address the Green Plan Commitments?

Click to view Green Plan

Not applicable

How will / does this work help to address inequalities?
This paper focuses on equity and equality for women and babies. Details are described in the paper and the full plan.
The following individuals were consulted and involved in the development of this report:
Partners in the Local Maternity and Neonatal System including Heads of Midwifery, Director of Midwifery, Equality, Diversity and Inclusion Leads (Trusts); Health Inequalities Programme Lead (ICS); Maternity Voices Partnerships; Digital Midwives; Public Health Midwife; LMNS Clinical Lead Midwife; LMNS Programme Manager; Deputy SRO/ Clinical Lead LMNS; LMNS Communications Manager ICS Health Inequalities Board Quality Improvement Manager, NHS England, East of England Maternity Clinical Network Public Health
Next steps:
Publish the action plan on the ICB website. Continue to progress implementation of existing initiatives and commence implementation of new initiatives in line with the action plan.
Appendices
Appendix A - Equity and Equality for Women, Babies and the Maternity and Neonatal Workforce: The Five-Year Action Plan for Bedfordshire Luton and Milton Keynes Local Maternity and Neonatal System 2022 – 2027 (the appendices to this document have not been included due to length however, they are available on request).

Action Plan Summary

1. **Background**

The recent MBRRACE-UK: Mothers and Babies report: "Reducing Risk through Audits and Confidential Enquiries" regarding maternal perinatal mortality still shows considerable differences in outcomes for women and babies from Black, Asian, and Mixed ethnic groups (BAME) and those living in the most deprived areas. Furthermore, the Covid-19 pandemic highlighted the urgency to prevent and manage ill health in those who experience the greatest health inequalities.

In September 2021, "Equity and Equality: Guidance for local maternity systems" was published in response to these findings with a clear ask of local maternity and neonatal systems to create a five-year plan setting out how we will work in partnership across the system to improve equity in outcomes for women and babies and improve race equality for staff.

The final Five-Year Plan for BLMK LMNS is attached for approval. It has been developed by a sub-group of the BLMK LMNS Board and approved by the BLMK ICS Inequalities Board last month. The Plan will evolve and be refreshed annually over the five years reflecting progress against interventions, timescales (the ambition is to achieve the timescales prescribed but recognise that flexibility is necessary) and performance against targets.

The overall aim of the strategy is to reduce the difference in outcomes for mothers and babies from both deprived communities and from BAME communities as well as improving working lives of the staff working across maternity and neonatal services in BLMK.

2. **What does the data say?**

We have reviewed the data available nationally for maternity and neonatal outcomes in Bedfordshire Luton and Milton Keynes and have also undertaken our own audit of maternity and neonatal data to understand where we need to focus. They show that:

- Increased deprivation correlates with women booking later into their gestation which impacts on timeliness of screening and care interventions.
- Black African women on average attend their first booking appointment four weeks later than White British women, thus impacting not just on the timing of some screenings but whether they are able to access them at all.
- Both deprivation and White ethnicity are linked to lower rates of initial breastfeeding.
- Prematurity rates were higher in lower deprivation deciles and in Black families.
- Rates of obstetric anal sphincter injury (OASI) vary by ethnicity with 3.93% of Asian women who had a vaginal birth experiencing a 3rd/4th degree tear compared to 2.25% of women with white backgrounds.
- In terms of outcomes for babies, still births and neonatal death rates are significantly higher compared with white and white other ethnicity groups.

3. **The Action Plan**

The Action Plan has developed based on what the data shows, what women and staff have told us and evidence of best practice from elsewhere. The Action Plan is aligned to interventions set out within the national Maternity Transformation Programme. It also includes additional interventions which have a local focus on improving outcomes for BAME women and their babies. These include:

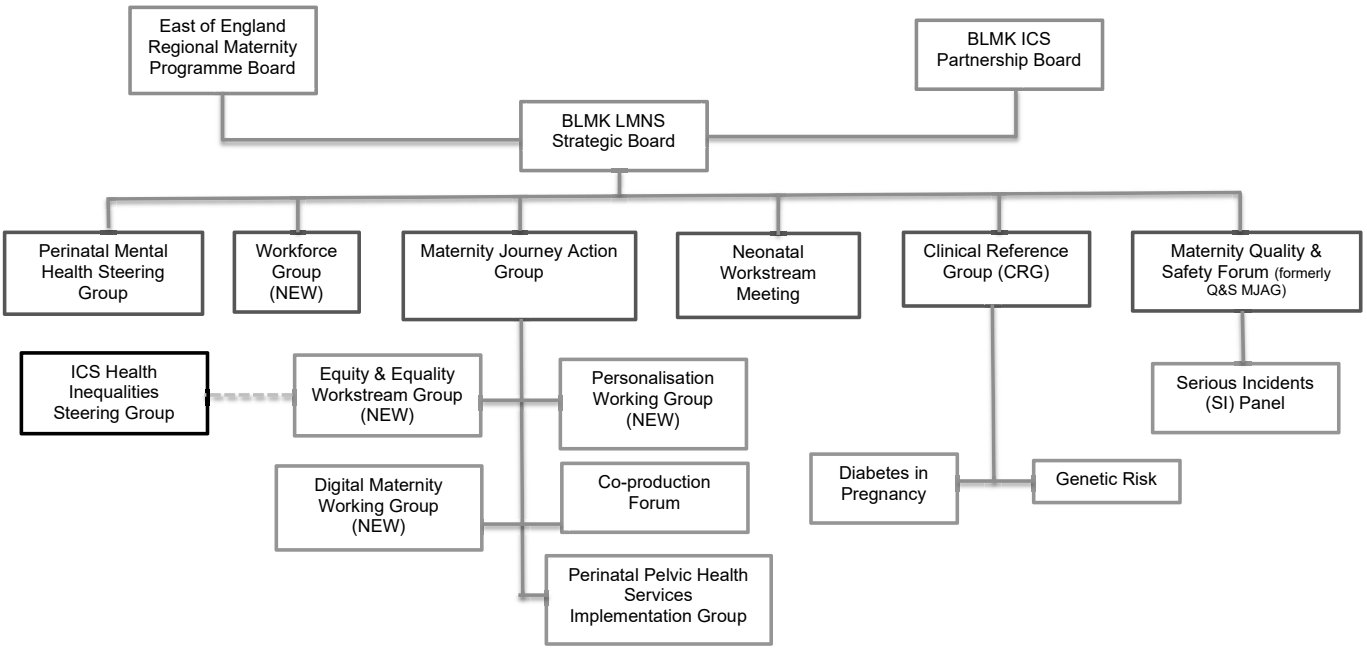
- A quality improvement approach for the Personalised Care and Support Plan including a digital version.

- Ensuring ethnicity recording continually improves and is maintained.
- Using our population health analysis to support engagement and in-reach to underserved communities.
- Ensuring that actions implemented as part of the Workforce Race Equality Scheme results are having an impact on staff.
- Working with our Maternity Voices Partnerships to ensure that their memberships are representative of the populations they serve.
- Continuing to support the building blocks for continuity of carer (when appropriate) so that this rolls out as a priority to BAME mothers.
- Implementing maternity-led smoke free support offer as part of the Tobacco Dependency Treatment Programme.
- Developing and implementing a breastfeeding strategy with a focus on those in deprived areas.
- Piloting the Genetic Risk Project with culturally appropriate support for those with close relative unions.
- Rolling out cultural competency training for all staff – working with Community of Cultures, led by the Sheffield Maternity Cooperative.
- Developing links with the Voluntary, Community and Social Enterprise sector to support and play an active part in the implementation of our interventions.
- Understanding how the Luton Cultural Community Workers project has impacted on outcomes and experiences for women and babies and also for staff working in services.
- Exploring the role of Social Prescribers in Primary Care and how they could support women from deprived and Black Asian and Mixed ethnic background – Social Prescriber Link Worker for maternity project in East Beds Primary Care Network.
- Maternity Sanctuary – exploring the opportunities that this project can bring for families who experience barriers when accessing maternity services.
- Pre-conception Services Project – supporting families to be aware of lifestyle interventions and how they can impact on pregnancy and further on in life.
- Use the findings from the Open Dialogue Workshops to help shape engagement with these communities going forward.
- Perinatal Pelvic Health Services – improving access to evidence-based services.

4. Governance

This plan has been developed under the governance of the Local Maternity and Neonatal System. Furthermore, it has also been reviewed and discussed and given full support by the Integrated Care System's Health Inequalities Group. We now seek full support and approval from the Integrated Care Board.

BLMK Local Maternity and Neonatal System (LMNS) Governance Structure (DRAFT)



Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

Equity and Equality for Women, Babies and the Maternity and Neonatal Workforce:

The Five-Year Plan for Bedfordshire Luton and Milton Keynes

Local Maternity and Neonatal System

2022 - 2027

Contents

1. Introduction / Background

The Covid-19 pandemic highlighted the urgency to prevent and manage ill health in those who experience the greatest health inequalities. In guidance produced by NHS England and NHS Improvement, they set out eight urgent actions for tackling health inequalities. Then as part of the 2021/22 priorities and operational planning guidance, systems were asked to focus on five priority areas, gathered from the eight actions.

- Priority 1: Restore NHS services inclusively
- Priority 2: Mitigate against digital exclusion
- Priority 3: Ensure data sets are complete and timely
- Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor health outcomes
- Priority 5: Strengthen leadership and accountability

In September 2021, Equity and Equality: Guidance for local maternity systems was published which set out how equity and equality in maternity and neonatal care is going to be improved under the five priorities.

This document sets out the plan for how the Bedfordshire Luton and Milton Keynes (BLMK) Local Maternity and Neonatal System (LMNS) will work in partnership with our maternity and neonatal services at Bedfordshire Hospitals NHS Foundation Trust (BHT) and Milton Keynes University Hospital NHS Foundation Trust (MKUH) and the wider system to improve equity for women and babies and race equality for staff through addressing the five priorities for tackling health inequalities over the next five years.

Furthermore, this action plan will evolve and be refreshed over the five years reflecting progress against interventions, timescales (it is our ambition to achieve the timescales prescribed but recognize that we need to be flexible) process and indicator measures and future guidance regarding national progress against health inequalities in maternity and neonatal services and the national maternity transformation programme.

2. Vision, values and aims

Our vision in the LMNS is to:

“P*romote equity and equality within our maternity and neonatal services and for our staff, as it is our responsibility to ensure that service users experience safe services and achieve parity in health and care outcomes regardless of ethnicity and socio-economic background”*.

We would like to achieve this vision because we are passionate about inclusion and ensuring a good to great experience for our service users and staff.

This is underpinned by our values which align with the equity and equality guidance:

- Proportionate universalism – ensuring universal action with a scale and intensity that reflects need
- Collaboration – a unified and coordinated effort across our many stakeholders is required, particularly in tackling the social determinants of health
- Coproduction – parents, families and staff working in partnership to improve clinical quality is more likely to result in culturally and socially relevant and clinically effective interventions.

The aims of this plan are two-fold:

- To improve equity for mothers and babies from Black, Asian, and Mixed ethnic groups and those living in the most deprived areas, and
- To achieve race equality for staff ensuring those from Black, Asian, and Mixed ethnic groups receive the same experiences and opportunities compared with the rest of the workforce.

3. LMNS Population and Health Outcomes – what the data say

Nationally, stillbirth rates remain unchanged between 2019 and 2020 at 3.8 stillbirths per 1,000 births and neonatal mortality rates continue the recent gradual decline to 1.3 deaths per 1,000 births in 2020[1]. Maternal mortality rates continue to decrease but not in a statistically significant way[2].

However, recent MBRRACE -UK reports about maternal perinatal mortality still show considerable differences in outcomes for women and babies from Black, Asian, and Mixed ethnic groups and those living in the most deprived areas.

Locally, our progress against reducing stillbirth, neonatal mortality and maternal mortality shows that we still have a way to go (see appendix 1 for the detailed analysis). These have heightened further due to the Covid-19 pandemic.

To understand the variation further in outcomes locally, we undertook a population health needs analysis for women and babies in BLMK. For our population health needs analysis, we focussed on births data from our Trusts between 1st April 2021 and 31st December 2021.

[1] ONS Child and infant mortality in England and Wales: 2020, Office for National Statistics, www.ons.gov.uk
[2] Saving Lives, Improving Mother's Care: Lessons learned to inform maternity care from UK and Ireland Confidential Equiries into Maternal Deaths and Morbidity 2017-2019, MBRRACE-UK, www.npeu.ox.ac.uk

What is our population?

BLMK has a total population of 1,088,931 (January 2022) of which around 21% (n=288,099) are of child-bearing age (aged 15-45)[3].

The population in this analysis were 46.2% White British, with 'White any other background' (17.1%) Asian-Pakistani (9.5%) and Black African (5.7%) the next largest population groups.

3.5% of the women and birthing people cared for by the three hospitals were in the lowest decile of Index of Multiple Deprivation (IMD 1). Overall, 50% were in the lower half of the IMD scale - exactly equivalent to the national average. Luton and Dunstable had the poorest population with 23.1% in the lowest quintile, with Milton Keynes and Bedford serving less deprived communities with 13.3% and 11.2% in the lowest quintile, respectively.

What does our data tell us about outcomes in relation to ethnicity and deprivation?

Our population health needs audit showed:

- Increased deprivation correlates with women booking later into their gestation which impacts on timeliness of screening and care interventions.
- Black African women on average attend their first booking appointment four weeks later than White British women, thus impacting not just on the timing of some screenings but whether they are able to access them at all.
- Both deprivation and White ethnicity are linked to lower rates of initial breastfeeding.
- Prematurity rates were higher in lower deprivation deciles and in Black families.
- Rates of obstetric anal sphincter injury (OASI) vary by ethnicity with 3.93% of Asian women who had a vaginal birth experiencing a 3rd/4th degree tear compared to 2.25% of women with white backgrounds.
- In terms of outcomes for babies, still births and neonatal death rates are significantly higher compared with white and white other ethnicity groups.

More detailed analysis can be found in appendix 2.

4. Measuring Outcomes

We will work collaboratively with the Inequalities Programme team to ensure the indicators and measures as part of this work feed into the wider Health Inequalities dashboard development. We will use this tool as means of measuring our progress on reducing inequalities.

[3] ONS Child bearing for women born in different years, England and Wales, Office for National Statistics, www.ons.gov.uk

5. Coproduction

Co-production is fundamental to delivering the transformation of maternity and neonatal services and is the golden thread running through our programme and LMNS.

Our aims for this are to:

- Understand what we are doing well and having a meaningful impact and where we need to improve
- Establish what we need to do to make our services culturally safe
- Understand how our populations would prefer us to engage and coproduce with them
- Design and commission services appropriate to the local demographic and that mitigate health inequalities.

It is important to gain the trust of the voices in our communities to receive fully honest information and not that which is either stifled or managed by others and past experience may have built up a mistrust between priority populations and the wider system/institution.

It is important to the LMNS that these relationships are built for us to develop our communications to best meet the needs of our local communities and support the decision making of local families (NICE CG110 p.4).

When we have an understanding or priority groups and entry points, we can seek to coproduce our engagement to enable us to gather the views of local people from Black, Asian, and other minority ethnic groups as identified in our data collection (NICE QS167 p.6). Our community asset map will support us to ensure we know where these groups are.

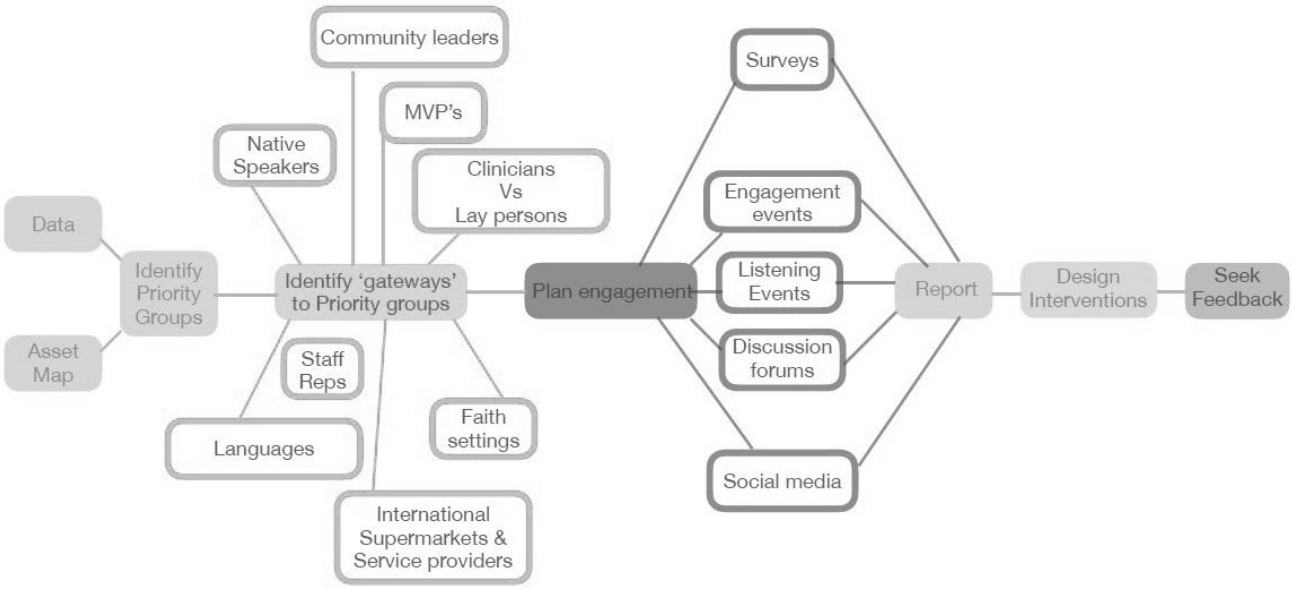
Engagement may be in the form of anonymous surveys, or it could be large scale engagement events. Throughout this it is important to us that our colleagues and stakeholders feel and are included in the work that we do and have a meaningful impact. Our Maternity Voices Partnership (MVP) & Healthwatch colleagues are also vital to the success of this work.

When we have engaged with our priority communities, we will be able to report on how best to tackle inequities and inequalities across our system.

Furthermore, we will work with the Coproduction Lead to ensure our approach is joined up and reflects an organizational approach to coproduction in BLMK.

The diagram below shows the flow of activities for the coproduction approach for our equity and equality action plan.

5.1 Equity and Equality Engagement Flow



6. Priorities 1 to 4 and Interventions

We will improve equity and equality in maternity and neonatal care aligned to the five priorities as set out in the guidance. We have undertaken a gap analysis (appendix 3) and assessment of progress against the five areas, and this forms the basis of our action plan.

Priority 1: Restore NHS Services inclusively

At a national level, the decline in access among some groups during the first wave of the pandemic broadly recovered in later months. Some pre-existing disparities in access, experience and outcomes have widened during the pandemic.

During the pandemic, the COVID-19 four actions were implemented across our LMNS, overseen by the Clinical Reference Group (CRG) and Maternity Journey Action Group (MJAG).

As part of this we:

- Co-produced an operational policy for managing the risks of COVID-19 for pregnant women from Black, Asian, and ethnic minority groups and implemented this to support those at-risk.
- Tailored communications were co-produced as an LMNS aiming to provide information about services e.g., breast feeding support, perinatal mental health and wellbeing support and the maternity journey during the pandemic. These materials were made available in languages common to our geography, simple and easy to

read using straightforward images and emoticons and in hard copy format. These were made available to maternity units to give out to women in appointments.
- Reviewed the clinical pathway to ensure that routine discussions on vitamins, supplements and nutrition were happening for all women to minimise vitamin D insufficiency.
- As part of CRG and MJAG discussions, confirmation was received that data on ethnicity and other risk factors were being routinely captured on maternity information systems so that those at risk of poor outcomes could be identified.

One of the gaps identified around the four actions is assurance that these continue to be reviewed and followed more than one year after the pandemic started. We will address this as an action to implement in our action plan.

Priority 2: Mitigate against digital exclusion

During the pandemic, many services moved to rapidly implement digital technologies that provided people with an alternative way to interact and access services as face-to-face methods were minimised during the pandemic.

For most maternity services in BLMK, they continued to operate face-to-face appointments alongside telephone consultations at various points in the maternity journey.

In the early part of the pandemic, the LMNS completed the design and development of its personalised care and support plan (PCSP), ensuring it was made available in a range of languages pertinent to our population, easy to read with opportunity for pregnant women to add in their own notes, and available in hard copy and in easy read format.

Given the changes to appointments in the maternity journey and the format they were available in, it was even more important to give women the opportunity to communicate perspectives, preferences and wants for their pregnancy journey. It was agreed to proceed to roll out the PCSP as soon as possible.

Since the restoration of services and return to face to face across the maternity journey, we now need to evaluate the implementation of the PCSP as well as understanding how it has been used and its impact on women so that we can evolve the paper PCSP and explore options for a digital version for those women who can and prefer to access in this way.

We will address this gap in our action plan and will form part of the LMNS Digital Maternity Strategy deliverables.

Priority 3: Ensure datasets are complete and timely

In line with COVID-19 action three, we continue to work with our Digital Midwives and business intelligence colleagues across the LMNS to ensure data collection and recording of ethnicity is continually improved.

This data is a requirement of the Maternity Services Data Set (MSDS) and is included as part of a wider requirement to report in line with the MSDS in the 10 Steps to Safety Actions and Ockenden Immediate and Essential Actions. These are overseen through our LMNS perinatal quality and oversight approach.

Within our Maternity services, a lot of work has been undertaken to ensure completeness in the collection and recording of ethnicity e.g., amending clinical templates to ensure all ethnic categories are reflected. According to the latest available (April 22) data on the national maternity services dashboard[4]:

- Bedfordshire Hospitals NHS Foundation Trust, 100% of records had an ethnicity recorded with only 1% of records showed ethnicity not stated, and
- Milton Keynes University Hospitals NHS Foundation Trust, all records showed ethnicity recorded.

The LMNS will continue to monitor this through existing processes and resources including the LMNS Dashboard and perinatal quality oversight approach.

Priority 4a: Understand your population and co-produce interventions

There are four interventions that support this priority and formed the basis of a submission to the national team in November 2021 and an updated submission in May 2022. As part of this, we:

- Commenced a population needs analysis so that we could begin to thoroughly understand the health outcomes in BLMK. However, further work is needed on the current version to build a more comprehensive picture and understanding.
- Created a community asset map which is available on Google docs meaning that we can share the link with system partners and Voluntary, Community and Social Enterprise (VCSE) organisations and other groups, allowing them to contribute to its creation but also to be able to use it as a resource. We are clear that this is an evolving document that will grow as we begin to reach out and engage with our populations and work together to co-design and develop interventions to address our inequality gaps in BLMK.
- A fundamental part of addressing inequalities in outcomes is understanding the ethnic composition of our workforce and understanding their experiences of working in maternity and neonatal services. We have worked with Equality and Diversity Leads in our Trusts to extrapolate the data from the Workforce Race Equality Survey and the actions that have been identified to address inequity for Black, Asian, and minority ethnic staff groups. Further work is required to clearly set the narrative around the results from the survey and what it means for our workforce.

[4] Microsoft Power BI – Maternity Services Dashboard

- During the pandemic, co-production became fundamental given the uncertainty for women in accessing information, clinicians and services. Through this experience, we have created an approach for co-production in our LMNS which covers not only service users but also our workforce. We continue to refine this further and develop our engagement plan and activities for this piece of work.

Priority 4b: Action on maternal mortality, morbidity, and experience

As part of this priority, LMNS are tasked with ensuring equity in access, experience, and health outcomes for women from Black, Asian, and minority ethnic groups and those living in the most deprived areas and consider other protected characteristics and inclusion groups.

Six interventions have been identified as contributing to delivering this:

- Implement maternal medicine networks (MMN) – these are commissioned on a regional footprint and BLMK have committed to support both the East of England MMN and the Thames Valley MMN to ensure equity of LMNS support for our population.
- Offer referral to the NHS Diabetes Prevention Programme for women with a past diagnosis of gestational diabetes mellitus (GDM) – as part of our work on the 6–8-week maternal post-natal check, we have worked to ensure that this is included in the check by primary care. By way of assurance that, as a preventative measure, these women are being offered referral, we need to consider how we evidence that this is being delivered e.g., audit.
- Implement NICE guidance CG110 antenatal care for pregnant women with complex social factors – this is implemented at Trust level but by way of assurance, we will look at a system wide workshop and use the quality assurance framework tool to benchmark progress and gaps towards the end of 22/23 and early 23/24.
- Implement maternal mental health services (MMHS) with a focus on ethnicity and deprivation – BLMK is one of the national pilot sites for MMHS with services now live in Bedfordshire and Luton and in Milton Keynes and closely aligned with existing Perinatal Mental Health Services. As services embed and receive referrals, activity, and outcomes e.g., access at ethnicity and deprivation level need to be monitored.
- Ensure personalised care and support plans are available to everyone – as per priority 2, PCSPs are in circulation across BLMK with an evaluation required on the implementation and effectiveness for pregnant women and staff.
- Ensure Maternity Voices Partnerships (MVPs) reflect the ethnic diversity of the local population. This has been identified as an area for improvement by our MVPs and some work has already been undertaken to address this. Following changes to co-chairs for Bedford and Luton MVPs, work is required to understand the diversity of their current membership and plans to address where this is not reflective.

Priority 4c: Action on perinatal mortality and morbidity

LMNS are asked to address the leading causes of perinatal mortality and morbidity for babies from Black, Asian, and Mixed ethnic groups and born to women living in the most deprived areas. LMNS may consider other protected characteristics and inclusion groups.

The interventions under this priority are:

- Implement targeted and enhanced continuity of carer, as set out in the NHS Long Term Plan. This means that, as continuity of carer is rolled out to most women, women from Black, Asian, and Mixed ethnic groups and women living in deprived areas are prioritised, with 75% of women in these groups receiving continuity of carer by 2024. It also means ensuring that additional midwifery time is available to support women from the most deprived areas.
- In BLMK, plans to implement Continuity of Carer include how this will be rolled out to the targeted groups above. However, further work is required to put in place the required building blocks to enable continuity of carer to be rolled out fully in line with the specification across the LMNS. The trajectories for this are aligned to the target in the Long-Term Plan.
- Implement a smoke-free pregnancy pathway for mothers and their partners. In BLMK, funding from the Tobacco Dependency Treatment Programme has been prioritised for maternity specific stop smoking support services. The LMNS is working with maternity services to implement the model
- Implement an LMNS breastfeeding strategy and continuously improve breastfeeding rates for women living in the most deprived areas. This is a gap, and we will address taking this forward as part of the action plan.
- Culturally sensitive genetics services for consanguineous couples. We are working with the Luton Public Health Team to implement support for these couples. This support will come in the form of a Genetic Risk Midwife, a genetics counsellor linked to the nearest genetics hub, investing in community literacy and training for workforce on consanguinity and genetic risk.

Priority 4d: Support for Maternity and Neonatal Staff

LMNS are asked to equip maternity and neonatal staff to provide culturally competent care and ensure maternity and neonatal staff experience race equality in the workplace. The interventions under this priority are:

- Roll out multidisciplinary training about cultural competence in maternity and neonatal services. In BLMK, funding in 2021 and 2022 has been provided to support bespoke cultural competence training across our services. The training is provided through the Community of Cultures Project led by the Sheffield Maternity

Collaborative and will provide training opportunities for all staff during 2022 and 2023. There will be an enhanced offer to provide train the trainer sessions to allow yearly training and updates for staff in BLMK going forward. What we need to understand as an LMNS is the impact for staff and how this has impacted behaviour and through service user feedback and other user experience surveys.

- When investigating serious incidents, consider the impact of culture, ethnicity, and language. The LMNS has reviewed its approach to learning from serious incidents by adding in culture/ethnicity and language into the Trust template for reporting, thus allowing incidents to be themed on this basis to support learning. Furthermore, we are planning to develop our quality improvement approach to ensure that actions to address the SI themes are delivering sustained improvements. This will include understanding the impact at ethnicity and deprivation level.
- Implement the Workforce Race Equality Standard (WRES) in maternity and neonatal services. Both Trusts in the LMNS have implemented the Workforce Race Equality Standard, which a requirement of providers in the NHS contract. As an LMNS, we will support Equity, Diversity, and Inclusion (EDI) Leads to ensure that they can analyse maternity and neonatal results at a granular level that facilitates intervention addressing inequalities and inequity for our workforce. We will also work with them to monitor impact of interventions following survey results. Furthermore, we will explore with EDI leads opportunities to educate the workforce on the WRES including why it matters and how the information will be used, and this could be included as part of annual appraisal, team learning days.

In addition to the above, it must be noted that there have been strides in recruitment of international midwives and nurses to support maternity and neonatal services. Alongside this, a specific support package is in place, including Practice Development Midwives, to ensure they are effectively supported as they transition and embed into local maternity services.

Priority 4e: Enablers

LMNS are asked to create the conditions to help achieve equity by considering the factors that will support high quality clinical care and, working with system partners and the VCSE sector to address the social determinants of health.

Interventions under this priority are:

- Establish community hubs in the areas with the greatest maternal and perinatal health needs. Within BLMK, we are working with both the Bedfordshire and Luton Family Hub programmes to ensure that maternity services in Bedfordshire are part of the development of family hubs and ensuring that these address where the unmet need is. Furthermore, we need to understand what the approach for Milton Keynes looks like.

- Work with system partners and the VCSE sector to address the social determinants of health. In BLMK, the LMNS has well developed relationships with Maternity Voices Partnerships and Healthwatch. Where we need to improve is reaching out into the wider community networks and groups who can support with meeting socio-economic needs which impact on demand for wider health and care services. We will create a plan to do this as part of this action plan initially considering how we work with the VCSE sector to host cultural key workers as part of our pre-conception services project.

7. Additional Interventions

Luton Community Cultural Key Workers Pilot

A pilot is underway in the maternity service at Luton and Dunstable Hospital looking at the role of community cultural key workers in providing support to Black, Asian and minority ethnic pregnant women and those living in deprived areas.

The role of the keyworker is to provide support for women to access to the service and antenatal appointments, supporting with community language and cultural acceptability and signposting to services that support the wider determinants of health.

This should deliver improved birth outcomes for babies, improved health outcomes for women, overall improve patient experience and service user satisfaction whilst achieving the recommendations set out in Better Births and continuity of care.

This is currently running as a yearlong pilot supported by the LMNS. The key workers commenced in post in the Autumn 2021 and anecdotally, have already begun to make an impact. We are awaiting the results of the local evaluation and will continue to work with maternity colleagues to understand the impact so far.

Social Prescribing Link Worker in Bedford

The LMNS is undertaking a joint initiative with Primary Care to understand how social prescribing can support pregnant people from mixed ethnic backgrounds and deprived areas. The project is in the early stages, but the plan is to invest in Social Prescribing Link Workers for 12 months to see how this model of support can improve access and outcomes for pregnant people from these particular backgrounds.

The pilot project will run within the East Beds Primary Care Network (PCN) whose population is ethnically diverse and has some of the lowest areas of deprivation. Community Midwives from Bedford Hospital who work within this PCN will be able to sign-post pregnant people to the Social Prescribing Link Worker who will be able to support from a socio-economic perspective.

Maternity Sanctuary

City of Sanctuary UK coordinates, supports and grows networks that welcome and support those forced to flee their homes. They have developed a maternity stream of their work which aims to build a culture of welcome within maternity services for people seeking sanctuary. Their aims are:

- To promote welcome, safety and inclusion within maternity services and support groups for pregnant women.
- To ensure that the voices of women in the asylum system are heard and considered when discussing the development of maternity related services and support groups.
- To help families overcome the barriers they experience when accessing maternity services.
- To develop a supportive community for women whilst providing opportunities for sharing relevant resources and best practice.

We will explore what this means for our LMNS and will consider this as an intervention within our actions to improve equity and equality for pregnant people.

Pre-conception Service Project

Locally we have the opportunity to improve access to pre-conception services for those from deprived and Black, Asian, and Mixed ethnic backgrounds following confirmation of funding for this from the ICB Health Inequalities funding allocation. This will allow us to develop community connectors within existing VCSEs to work collaboratively with community midwives to support women to access preconception and early antenatal care.

These will be place-based around each of our maternity units and will specifically support those women with medical conditions such as sickle cell, early diabetes, and hypertension.

Open Dialogue Workshops

The LMNS in partnership with Luton Borough Council commissioned the East of England Local Government Association to undertake three open dialogue workshops between April and July 2022 to gather the views from key community groups regarding COVID-19 vaccine hesitation. Three workshops were arranged with Luton Roma Trust, South Asian women, and Bury Park.

We will use insight from these workshops to tailor our approach to supporting these groups to come forward for their Covid vaccinations and other pregnancy related vaccinations. Additionally, we will also explore how this insight can support other projects within the maternity transformation programme.

Perinatal Pelvic Health

BLMK LMNS is a fast follower for Perinatal Pelvic Health Services. This means we can build on current pelvic health provision locally and align with an evidence-based set of service principles. The overall aim is to improve the prevention, identification, and treatment

of ‘mild to moderate’ pelvic floor dysfunction following birth, and ultimately reduce the number of women living with pelvic floor dysfunction postnatally and in later life.

Addressing inequalities for Black Asian and Mixed ethnic groups and women from most deprived areas is in scope for this project and we will be planning to address the barriers in accessing services for these groups by:

- Considering language resources available, ensuring they are of high quality. This includes health literate interpreters, translated materials and infographics
- Looking at opportunities for enhanced care for defined cohorts e.g., group antenatal care, additional Health Visitor support
- Exploring the role of peer support e.g., peer befriending, trained volunteers
- Tailoring patient education
- Opportunities to facilitate easier access to female clinicians.

Lifestyle Factors – Obesity

We are developing our approach with public health colleagues to support projects focussing on lifestyle factors such as obesity. These projects will have a focus on access and support to make those modified changes which impact on outcomes for pregnant people and their families and further on in life.

Connecting with other system-wide initiatives

Link into other ICS system initiatives with inequalities focus e.g., Primary Care Inequalities Group, to explore possible links for maternity services.

Website containing information and resources for maternity and neonatal services.

We will develop an online resource via the health and care partnership website which will provide information, resources, and signpost to support for pregnant women and people and their families on all aspects relating to maternity and neonatal services including this equity and equality action plan.

8. Actions, milestones, and metrics

The table below is the high-level action plan setting out the actions identified earlier in this document, owners, indicative timescales, and the outcome measures. There is a more detailed project plan that sits behind this with further detail around the actions.

Priority	Intervention	Actions	Owner	Timescales	Indicators – Process (P) / Outcomes (O)
1: Restore NHS Services inclusively	Continue to implement the Covid-19 four actions	Undertake audit to ensure the four actions continue to be implemented	Better Births Leads in Trusts	End of Q4 22/23	(P) Implementation of the COVID-19 four actions (O) Women using folic acid (source: Regional Measures Report)
2: Mitigate against digital exclusion	Ensure personalised care and support plans (PCSPs) are available in a range of languages and formats, including hard copy PCSPs for those experiencing digital exclusion	Evaluate effectiveness and impact of PCSP and revise subject to outcome	LMNS Clinical Lead Midwife	End of Q3 22/23	(P) The number of women with a Personalised Care and Support Plan which covers: • antennal care by 17 weeks gestation • intrapartum care by 35 weeks gestation • postnatal care by 37 weeks gestation The numbers of women who had all three of the above in place by the gestational dates
		Explore options to digitalise the current version including investment required		By Q2 23/24	

3: Ensure datasets are complete and timely	On maternity information systems continuously improve the data quality of ethnic coding and the mother's postcode.	Monitor ethnicity coding and mother's postcode through the LMNS Dashboard, National Maternity Services Dashboard and contract reporting as appropriate	Digital Midwives/ Maternity Quality Manager	Ongoing	P) Safety action 2, category 9: data submitted to Maternity Services Data Set (MSDS) contains valid postcode for mother at booking in 95% of women booked in the month. • Ethnicity data quality (source: Regional Measures Report). • Safety action 2, category 10: data submitted to MSDS includes a valid ethnic category for at least 80% of the women booked in the month. Not stated, missing and not known are not valid records.
4a: Understand your population and co-produce interventions	Understand the local population's maternal and perinatal health needs (including the social determinants of health).	Produce Population Analysis	LMNS Programme Manager/Clinical Lead/Data and Outcomes Midwife	May 22	None
	Map the community assets which help address the social determinants of health.	Produce Community Asset Map	LMNS Programme Manager	March 22	
	Conduct a baseline assessment of the experience of maternity and neonatal staff	Gather baseline assessments from Trust EDI leads and action plans	Trust EDI Leads	May 22	

	by ethnicity using WRES indicators 1 to 8.				
	Set out a plan to co-produce interventions to improve equity for mothers, babies and race equality for staff.	Produce co-production approach and plan	LMNS Communications & Engagement Manager	March 22	
4b: Action on maternal mortality, morbidity, and experience	Implement maternal medicine networks to help achieve equity.	Ensure LMNS is committed to supporting Oxford and Cambridgeshire MMN Hubs	LMNS Programme Manager	May 22	The Maternal Medicine Network is implementing the KPIs in the non-mandatory national service specification. They are broken down by level of deprivation of the mother's postcode and ethnicity • Booking at <70 days gestation (source: Regional Measures Report) • Proportion of women with complex social factors who attend booking by 10 weeks, 12+6 weeks and 20 weeks (source: Regional Measures Report) • For each complex social factor grouping, the number of women who: attend for booking by 10, 12+6 and 20 weeks; and attend the
		Ensure pathways and learning is shared across BLMK from both hubs	LMNS Clinical Lead/Deputy SRO	Ongoing	
	Offer referral to the NHS Diabetes Prevention Programme to women with a past diagnosis of gestational diabetes mellitus (GDM) who are not currently pregnant and do not currently have diabetes.	Ensure 6-8week post-natal check in primary care includes discussion about Diabetes and the prevention programme	Diabetes in Pregnancy Group / LMNS Clinical Lead/Deputy SRO	Ongoing	
		Explore opportunity to include in primary care audits with regards to identification of cohort for possible referral			
	Implement NICE CG110 antenatal care for pregnant women with complex social factors.	System-wide workshop focussing on NICE CG110 on the data tool	LMNS Clinical Lead/Deputy SRO	Q4 22/23 – Q1 23/24	
		Use the quality assurance framework tool to benchmark current position and gaps and develop an action plan			

	Implement maternal mental health services with a focus on access by ethnicity and deprivation.	Maternal Mental Health Services implemented across BLMK. Once embedded, discuss approach to addressing access for ethnic and deprived groups	BLMK Mental Health Improvement Manager	End of Q4 22/23	recommended number of antenatal appointments • % of parent members of the MVP who are from ethnic minority groups • % of women attending the booking appointment who are from ethnic minority groups (source: Regional Measures Report) • Ethnicity data quality (source: Regional Measures Report)
	Ensure personalised care and support plans are available to everyone.	Monitor via MSDS reporting indicator (once issues resolved)	LMNS Clinical Lead Midwife		
		See priority 2			
	Ensure the MVPs in your LMS reflect the ethnic diversity of the local population, in line with NICE QS167.	Work with MVP to identify demographic at ethnicity level for their locality	LMNS Clinical Lead Midwife/ LMNS Programme Manager	End of Q3 22/23	
		Ensure actions to deliver this are included in the MVP annual workplan and link with the community asset map.	Co-Chairs MVP	End of Q4 22/23	
4c: Action on perinatal mortality and morbidity	Implement targeted and enhanced continuity of carer, as set out in the NHS Long Term Plan. This means that, as continuity of carer is rolled out to most women, women from Black, Asian and Mixed ethnic groups and women living in deprived areas are prioritised,	MCoC roll out plans which address Black, Asian and Mixed ethnic groups and women in deprived areas prioritised	LMNS Clinical Lead Midwife	End of Q4 2024	(P) • Breast milk at first feed • Low birth weight (<2,500g for term births) • Deliveries under 27 weeks • Deliveries under 37 weeks

	with 75% of women in these groups receiving continuity of carer by 2024. It also means ensuring that additional midwifery time is available to support women from the most deprived areas.				(O) Placement on a continuity of carer pathway – Black/Asian women • Placement on a continuity of carer pathway – women living in the most deprived areas • Baby Friendly accreditation
	Implement a smoke-free pregnancy pathway for mothers and their partners.	Implement maternity-led stop smoking service as part of the Tobacco Dependency Treatment Programme	LMNS Public Health/Prevention Midwife	End of Q4 2024	
	Implement an LMS breastfeeding strategy and continuously improve breastfeeding rates for women living in the most deprived areas.	Attend webinar *Learn how to go about coproducing a breastfeeding strategy in your LMS or Local Authority, based on our case study from North Central London* 7th September Develop plan LMNS Breastfeeding Strategy	LMNS Public Health/Prevention Midwife/ MVP Co-chair	2023/2024	
	Culturally sensitive genetics services for consanguineous couples.	Submit application for national support for Luton Genetic Risk Project Create project plan	LMNS Clinical Lead/Deputy SRO Luton Public Health	September 2022 – 2025	

		Implement project			
4d: Support for Maternity and Neonatal Staff	Roll out multidisciplinary training about cultural competence in maternity and neonatal services.	Ensure funded training is rolled out to both maternity and neonatal teams across both Trusts	Deputy Head of Midwifery MKUH	End of Q2 22/23	(P) • Breast milk at first feed • Low birth weight (<2,500g for term births) • Deliveries under 27 weeks • Deliveries under 37 weeks (O) Placement on a continuity of carer pathway – Black/Asian women • Placement on a continuity of carer pathway – women living in the most deprived areas • Baby Friendly accreditation (P) • WRES indicators 1 to 8 for midwives and nurses in maternity and neonatal services
		Work with Trust teams to understand how we capture and monitor impact on behaviours of clinical staff	LMNS Programme Manager/Heads of Midwifery	2023/24	
		Work with MVP to identify impact on service user feedback and other user experience approaches	LMNS Programme Manager/ MVP Co-Chairs	2023/24	
	When investigating serious incidents, consider the impact of culture, ethnicity and language.	Develop quality improvement approach to ensure actions are delivering sustained improvements, to include outcomes measures at ethnicity and deprivation level.	LMNS Clinical Lead/Deputy SRO	Ongoing	
	Implement the Workforce Race Equality Standard (WRES) in maternity and neonatal services.	Ensure action plan created in response to feedback and monitor impact through future survey results	Trust EDI Leads/Heads of Midwifery and Neonatal leads	Annually following the WRES surveys	

		Work with EDI leads to educate workforce on the WRES/WDES including why it matters and how information will be used.	Trust EDI Leads/Heads of Midwifery and Neonatal leads	2023/24	(O) • % of maternity and neonatal staff who attended training about cultural competence in the last two years • % of maternity and neonatal Serious Incidents relating to patient care with a valid ethnic code • % of Perinatal Mortality Review Tool cases with a valid ethnic code
4e: Enablers	Establish community hubs in the areas with the greatest maternal and perinatal health needs.	Work with the Bedford and Luton Family Hubs Programme to ensure maternity services are reflected in the development of and design approach	Better Births Leads, Trusts	2022 - 2025	None
	Work with system partners and the VCSE sector to address the social determinants of health.	Create an action plan for working with the VCSE ensuring it is aligned to the ICS Health Inequalities programme to share approaches – use the pre-conception project as an opportunity to explore this	LMNS Clinical Lead/Deputy SRO ICS Health Inequalities Programme Lead	Q3 22/23 – Q2 23/24	

Additional Interventions	Luton Cultural Community Workers	Evaluation and modify as required	Deputy Head of Midwifery Luton & Dunstable	Q3 22/23	To be locally developed
	Bedford Social Prescribing Link Worker Project	Implement pilot project with East Beds Primary Care Network	LMNS Clinical Lead/Deputy SRO Primary Care Transformation Manager	Q3 22/23 – Q2 23/24	To be locally developed
		Evaluate and make recommendations based on evaluation outcomes			
	Maternity Sanctuary	Explore appetite for involvement locally within a regional model	LMNS Programme Manager	Q2 – Q4 22/23	To be locally developed
	Pre-conception Project	Develop community connector approach to support access to preconception and early antenatal care	LMNS Clinical Lead/Deputy SRO	Q3 – Q4 22/23	To be locally developed
		Review preconception tool and create action plan	Obstetrician support (MKUH)		
		Work with MVP to develop and support preconception promotion	LMNS Clinical Lead/Deputy SRO		
	Open Dialogue Workshops	Review feedback and recommendations from the report and feed into the engagement and coproduction approach	LMNS Clinical Lead/Deputy SRO LMNS Programme Manager	Q2 22/23 – 23/24	None

	Perinatal Pelvic Health Services (PPHS)	Create inequalities plan that addresses barriers to access	PPHS Project Manager	Q3 22/23	To be locally developed
	Lifestyle Factors - Obesity	Work with Public Health colleagues to develop projects which focus on lifestyle factors.	Public Health Teams/Deputy SRO	22/23 – 23/24	To be locally developed
	Linking in with System-wide initiatives	Identify other ICS system initiatives with a inequalities focus and link to maternity services	LMNS Clinical Lead/Deputy SRO	2022 - 2027	None
	ICB website – maternity and neonatal repository	Action plan to develop maternity and neonatal specific content for the ICB website and implement	LMNS Programme Manager	Q3 – Q4 22/23	None

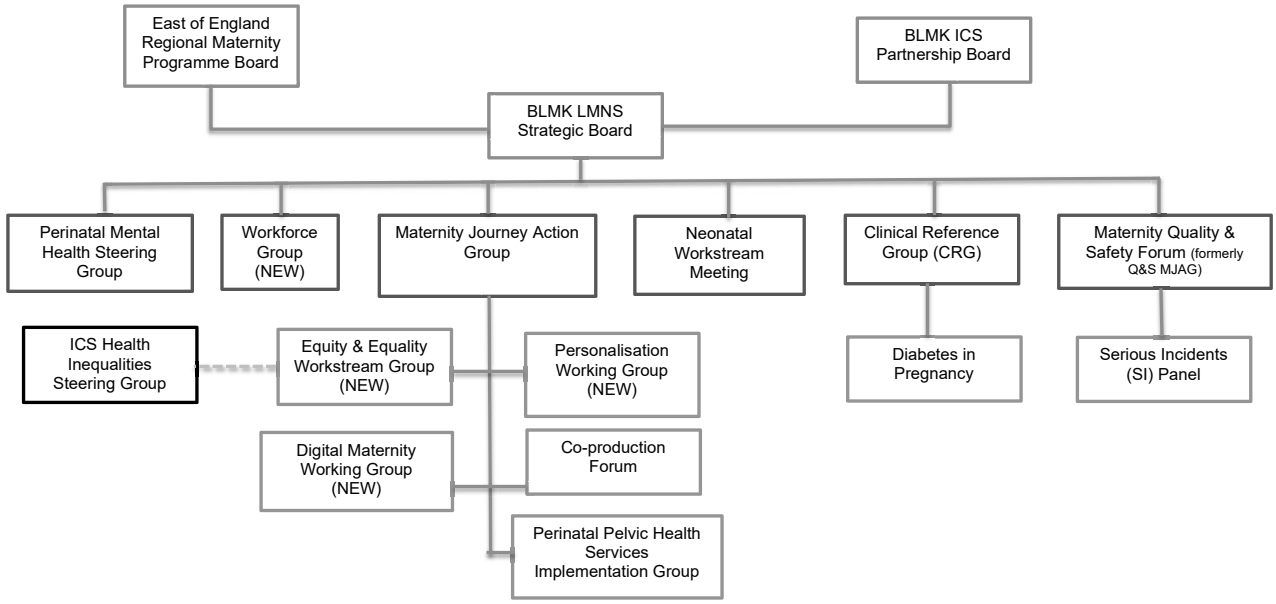
9. Continuous quality improvement

Continuous quality improvement is fundamental to ensuring that the interventions implemented to address health inequalities are driving the required impact on outcomes.

Continuous quality improvement will sit with the project teams leading implementation of interventions. We will link in with the Health Inequalities Improvement Advisor to ensure that our interventions have a robust quality improvement approach built in.

All quality improvement initiatives will be overseen in line with the LMNS governance structure.

BLMK Local Maternity and Neonatal System (LMNS) Governance Structure (DRAFT)



The Quality and Safety Meeting is responsible for the oversight of perinatal quality outcomes for the LMNS and include continuous quality improvement. This group also escalates and provides assurance to the Strategic Board on quality and safety within the LMNS.

10. System roles and responsibilities

Delivery of this 5-year action plan will only be achieved through working collaboratively across the ICS. The table below shows the roles and responsibilities of those within our system who have a key part to play in this.

Roles	Responsibilities
LMNS Senior Responsible Officer (SRO)	Accountable for delivery of the 5-year action plan
LMNS Clinical Lead/Deputy SRO	Responsible for providing and overseeing clinical leadership
LMNS Programme Manager	Responsible for coordinating the implementation of the action plan
Trust Executive Board Level Leads for Health Inequalities	Responsible for providing leadership for health inequalities at Trust Board level
Trust Board Safety Champions for maternity and neonatal services	To champion interventions within the Equity & Equality Action Plan aimed at reducing inequalities in maternity and neonatal services at Trust Board meetings
Heads of and Director of Midwifery	To support and champion implementation of interventions within their services
Trust Equality Diversity and Inclusion Leads	Responsible for delivery of the WRES and actions to address equity for the maternity and neonatal workforce
Intervention/Project Leads	Responsible for delivery of the interventions and associated outcomes for reducing health inequalities and improving equity
Maternity Voices Partnerships	Responsible for coordinating the service user voice throughout the equity and equality workstream
ICS Health Inequalities Programme Lead	Responsible for providing support and ensuring alignment of initiatives with the wider ICS Health Inequalities programme of work.

11. Interdependencies with ICS priorities and workstreams

Health inequalities is one of the five strategic priorities in the BLMK ICS. The LMNS 5-year Equity and Equality Action Plan is aligned to this priority and will report into the Health Inequalities Working Group and Steering Group.

12. Core20PLUS5

The ICS is also using the Core20PLUS5 approach to support reducing health inequalities within our system.

Core20 is the most deprived 20% of the population as identified by the Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

PLUS are the other population groups including ethnic minority communities, inclusion health groups, people with learning disabilities and/or autism; people with multiple morbidities and protected characteristic groups.

5 are the five areas of clinical focus and align to national programmes, with coordination of efforts overseen by national and regional teams to achieve national aims.

Maternity is one of the areas of clinical focus and the specific aim is to ensure continuity of care is available for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.

Through Core20PLUS5, the LMNS will work with the ICS Health Inequalities team through a quality improvement approach to ensure that maternity services are able to achieve the aim above and impact on health inequalities through 'community connector' approaches.

13. Resourcing including funding

This work will be supported through existing people resources who are already working on initiatives as part of the maternity and neonatal transformation programme.

The work will be supported financially through the national transformation funding devolved to LMNS, the ICS Health Inequalities allocation and Core20PLUS5 programme. Through this funding, we will commit investment where required to support our journey to improving equity and equality in BLMK. This includes funding to:

- Support enhanced continuity of carer for Black, Asian and minority ethnic groups as well as those from our most deprived areas.
- Support local interventions such as the Luton Cultural Community Key Worker project.
- Support translation and creation of information aides for women and their families in languages pertinent to our population. This also includes ensuring that these are available in a range of formats to ensure ease of access and reduce exclusion.
- Support the development of and raising awareness amongst our maternity, neonatal and obstetric workforce of cultural competency and personalisation through training and education.
- Support engagement with the range of hard-to-reach communities through a range of methods e.g., open dialogue workshops, that allow us to build trust and relationships with these communities.
- Investing in our Maternity Voices Partnerships, recognising the value and contribution they bring through their membership's experiences to the LMNS.
- Possible investment into a project lead to oversee ongoing implementation and monitoring of the action plan.
- Quality Improvement Advisor to support the quality improvement approach to our interventions.

14. High-level Stakeholder Communication Plan

Stakeholder (who)	Messages (what)	Format (how)	Frequency (when)	Responsible
ICS Health Inequalities Steering Group	Progress updates; issues and risks; funding	Meetings; papers; presentation; highlight report	Bi-monthly	LMNS Clinical Lead/LMNS Programme Manager
ICS Health Inequalities Working Group	Progress updates; intervention specific updates	Meetings; presentation; papers	As required (rotational basis)	LMNS Clinical Lead/LMNS Programme Manager
LMNS Strategic Board	Progress updates; issues and risks; funding; intervention level deep dive	Meetings; papers; highlight report	Bi-monthly	LMNS Clinical Lead/LMNS Programme Manager
Maternity Journey Action Group	Intervention level deep dive; progress updates	Meetings, presentation/ papers	As required	LMNS Clinical Lead/LMNS Programme Manager/ Intervention Leads
Equity & Equality Action Plan Task & Finish Group	Roles; responsibilities; progress updates; issues and risks	Meetings, emails, highlight reports	Monthly	LMNS Clinical Lead/LMNS Programme Manager/ Intervention Leads
Trust maternity and neonatal teams	Progress updates; issues and risks; funding; service user input	Meetings, emails, papers	Monthly or as required	Intervention Leads
Trust Board Safety Champions and Inequalities Leads	Progress updates	Meetings, emails, papers	As required	LMNS Clinical Lead/LMNS Programme Manager/ Heads of Midwifery
Trust EDI Leads	Progress updates	Meetings, emails, papers	As required	LMNS Clinical Lead/LMNS Programme Manager/

				Intervention Leads
Public Health Colleagues	Progress updates; intervention specific updates	Meetings, emails, papers	As required	LMNS Clinical Lead/LMNS Programme Manager
Service Users/Maternity Voices Partnerships	Progress updates; intervention specific updates; requests for service user involvement, feedback and outputs	Meetings, emails, papers	Monthly or as required	LMNS Clinical Lead/LMNS Programme Manager/ Intervention Leads
Regional Looking Beyond Equity Equality Workstream meeting	Progress updates; risks and issues	Meetings, emails, papers	As required	LMNS Programme Manager

Appendix 1 – Mortality Analysis

Appendix 2 - BLMK LMNS Equity & Equality Health Analysis and Coproduction

Appendix 3 – Gap Analysis

Please note: the appendices to this document have not been included due to length however, they are available on request.

Glossary

10 Steps to Safety – an incentive element of the scheme that supports delivery of safer maternity care. The ten safety actions are designed to improve the delivery of best practice in maternity and neonatal services.

Better Births – a five-year forward view for improving outcomes in maternity care. It specifically sets out the vision for planning, designing safe delivery of maternity services.

Social Determinants of Health – the conditions with which people are born, grow, work, live and age and the wider forces and systems that shape the conditions of daily life and health of our population.

Clinical Reference Group – a group comprising of maternity, obstetric and neonatal clinicians who come together to work on safety and quality initiatives that will improve outcomes for maternity and neonatal services.

Community Hubs – a local centre where women can access different aspects of their maternity care.

Continuity of Carer – a way of delivering maternity care so that women receive dedicated support from the same midwifery team throughout their pregnancy.

Continuous Quality Improvement – an approach to delivering step-by-step improvements in processes, safety, and patient care.

Co-production – an approach to decision-making and service design through understanding the needs of service users and engaging them closely in the design and delivery of services.

Cosanguineous Couples – close-relative relationships

Cultural Competence – the ability to effectively interact with people from different cultures through a knowledge and appreciate of cultural differences.

Health Inequalities – differences in health between people or groups of people that may be considered unfair.

Healthwatch – the independent champion for those who use health and social care services. Their purpose is to understand what matters to local people and help to make sure that views shape the support needed.

Integrated Care Board (ICB) – the statutory organization bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS.

Integrated Care System (ICS) – partnership of organisations that come together to plan and deliver joined up health and care services and to improve the lives of people who live and work in their area.

Local Maternity and Neonatal System (LMNS) – a group of people locally involved in either providing, receiving or commissioning maternity and neonatal care.

LMNS Dashboard – a tool for monitoring progress against targets for a range of clinical and non-clinical indicators for maternity and neonatal services.

Maternal Mental Health Service – a service combining maternity, reproductive health and psychological therapy for women experiencing moderate to severe or complex mental health difficulties directly arising from, or related to, their maternity experience.

Maternal Medicine Network – a service providing pre-pregnancy, antenatal and postnatal care for women who have significant medical problems that pre-date or arise in pregnancy or the puerperium.

Maternity Journey Action Group (MJAG) – a group comprising of people from the LMNS who come together to oversee progress against the maternity transformation programme.

Maternity Services Data Set – a patient-level data set that capture information about activity carried out by Maternity Services relating to a mother and baby (s), from the point of the first booking appointment until mother and baby (s) are discharged from maternity services.

Maternity Voices Partnership – a NHS working group: a team of women and their families, commissioners, and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.

NHS Diabetes Prevention Programme – a programme that identifies people at risk of developing type 2 diabetes and refers them to an evidence-based lifestyle change programme.

Ockenden Immediate and Essential Actions – actions for implementation by local trusts as outlined in the interim and final Ockenden report following the review of maternity services at Shrewsbury and Telford Hospital NHS Trust.

Perinatal Pelvic Health Service – a service providing support to prevent and treat incontinence and other pelvic health issues throughout pregnancy.

Personalised Care and Support Plans (PCSP) – a document that support pregnant people to identify and capture what matters to them when using maternity services and make sure that their care reflects this.

Preconception care – improving the long and short-term health outcomes of women and their children; allowing physical and mental health conditions and social needs to be addressed and managed prior to pregnancy; allowing women to be aware of potential risks and make an informed decision about their pregnancy.

Primary Care Network (PCN) – groups of practices working together to focus local patient care.

Serious Incidents – adverse events that have a profound impact on patients, carers, NHS staff or NHS organisations.

Voluntary Community and Social Enterprise (VSCE) – a non-governmental organization that is value-driven and reinvests its surpluses to further social, environmental, cultural objectives.

Workforce Race Equality Scheme (WRES) – a framework for achieving race equality in the workplace in NHS organisations.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
15. NHS Bedfordshire, Luton & Milton Keynes Clinical Commissioning Group Annual Report & Accounts 2021/22

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☐	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☐	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☐	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☐	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☐	Ways of working ☐	Estates ☐
Communications ☐	Finance ☐	Operational and Clinical Excellence ☐	Governance and Compliance ☒
Other ☐ (please advise):			

What are the members being asked to do?		
Approve ☐	Note ☒	Discuss ☐

Report Author	Gaynor Flynn, Governance & Compliance Manager
Date to which the information this report is based on was accurate	20th September 2022
Senior Responsible Owner	▪ Maria Wogan, Chief of System Assurance and Corporate Services ▪ Stephen Makin, Deputy Chief Finance Officer

Executive summary

As a legal entity NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group (CCG) was required to produce Annual Reports & Accounts for:

1. The Financial Year 2021/22
2. April 2022 to June 2022 (quarter 1)

The Board of the Integrated Care Board will be required to approve submission of the CCGs Annual Report & Accounts for April to June 2022. The current proposed timeline set by NHS England for submission is Summer 2023. We await confirmation of this and further information from NHS England and will provide updates accordingly.

This report details the CCGs Annual Report & Accounts for 2021/22 (the report)

On 14 June 2022
The report was presented to the CCGs Governing Body by the Director of Performance & Governance and the Deputy Chief Finance Officer. At the time of presentation, the report had been audited by NHS England and the CCGs External Auditors audit of the report was ongoing.

Members of the Governing Body were asked to:

- approve the report (as recommended at the 14 June CCG Audit Committee) and,
- agree for the Governing Body to delegate final approval of outstanding amendments or adjustments between then and final submission to NHS England and NHS Improvement, to the Accountable Officer and Chief Finance Officer following recommendations from the Director of Performance & Governance and Deputy Chief Finance Officer.

The report and delegated authority for final approval was approved.

Members of the Governing Body were also asked to confirm the following 'Statement of disclosure to auditors' in section 6 of the Corporate Governance section (part of the Accountability Reports). The statement reads as follows:

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report;
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Members of the Governing Body confirmed the Statement of Disclosure to Auditors.

On 16 June 2022
Following 14 June 2022 Audit Committee, independent external Auditors (Grant Thornton) completed their audit of the report and issued an unqualified opinion on the financial statement and an opinion on regularity, noting that they could not formally conclude the audit and issue an audit certificate in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until they had completed their work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources.

On 22 June 2022
The report was submitted to NHS England and NHS Improvement.

On 2 September 2022
External Audit presented their Auditors Annual Report to the Audit & Risk Assurance Committee.

On 16 September 2022
External Audit issued a Closure Letter, a report on the Audit of the Financial Statements, an Audit Certificate and confirmed that no matters have come to their attention since 16 June 2022 that would have a material impact on the financial statements on which they gave their opinion and issued.

Outcome
NHS Bedfordshire, Luton & Milton Keynes CCG achieved its statutory financial duties to keep expenditure within the resources available and ensured that our Running Costs remained within the Running Costs allocation.

External Audit gave an unqualified opinion on the Annual Accounts 2021/22. This means that the annual accounts give a true and fair view of the financial affairs of the CCG and of the income and expenditure recorded during the year. Our external auditors concluded that there were no significant weaknesses in value for money arrangements in the CCG.

What are the available options?

Following the disestablishment of CCGs on 30 June 2022, NHS England advised the ICB that if a CCG did not hold an Annual General Meeting (AGM) by 30th June 2022, the relevant ICB can present the CCG Annual Report and Accounts at a public board meeting, in lieu of a CCG AGM.

Recommendation/s

The Board of the ICB is asked to **note** the:

- Audit Certificate – appendix A
- NHS Bedfordshire, Luton & Milton Keynes Clinical Commissioning Group Annual Report & Accounts 2021/22 – which can be found on the ICB public website https://bedfordshirelutonandmiltonkeynes.icb.nhs.uk/our-publications/annual-reports/

Key Risks and Issues

There are none identified.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

Not Applicable

Are there any financial implications or other resourcing implications?

There are none identified.

How will / does this work help to address the Green Plan Commitments?
Click to view Green Plan

Not Applicable

How will / does this work help to address inequalities?

Not Applicable

The following individuals were consulted and involved in the development of this report:

- Geraint Davies, Director of Performance and Governance
- Sarah Feal, Head of Governance
- Maria Wogan, Chief of System Assurance and Corporate Services
- Stephen Makin, Deputy Chief Finance Officer

Next steps:

None required – all documentation has been published on the ICBs Public Website.

Appendices

- Appendix A – Audit Certificate

Independent auditor's report to the members of Bedfordshire, Luton and Milton Keynes Integrated Care Board in respect of Bedfordshire, Luton and Milton Keynes CCG

In our auditor's report issued on 16 June 2022, we explained that we could not formally conclude the audit and issue an audit certificate for Bedfordshire, Luton and Milton Keynes CCG (the 'CCG') for the year ended 31 March 2022, in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until we had completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2022 issued on 16 June 2022 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

In forming our opinion on the financial statements, we drew attention to note 24 to the financial statements, which describes that under the Health and Care Act (2022), which received Royal Assent on 28 April 2022, the commissioning functions of NHS Bedfordshire, Luton and Milton Keynes CCG will transfer to Bedfordshire, Luton and Milton Keynes Integrated Care Board. The expected date of the transfer is 01 July 2022.

No matters have come to our attention since 16 June 2022 that would have a material impact on the financial statements on which we gave this opinion.

Report on other legal and regulatory requirements - the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

The Accountable Officer of the CCG was responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibilities for the review of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources were operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG planned and managed its resources to ensure it could continue to deliver its services;
- Governance: how the CCG ensured that it made informed decisions and properly managed its risks; and
- Improving economy, efficiency and effectiveness: how the CCG used information about its costs and performance to improve the way it managed and delivered its services.

We have documented our understanding of the arrangements the CCG had in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there were significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of Bedfordshire, Luton and Milton Keynes CCG for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of Bedfordshire, Luton and Milton Keynes Integrated Care Board, as a body, in respect of Bedfordshire, Luton and Milton Keynes CCG in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of Bedfordshire, Luton and Milton Keynes Integrated Care Board those matters we are required to state to them in an auditor's report in respect of Bedfordshire, Luton and Milton Keynes CCG and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than Bedfordshire, Luton and Milton Keynes Integrated Care Board and the members of Bedfordshire, Luton and Milton Keynes Integrated Care Board as a body Bedfordshire, Luton and Milton Keynes CCG and the Governing Body of Bedfordshire, Luton and Milton Keynes CCG as a body, for our audit work, for this report, or for the opinions we have formed.

Paul Grady

Paul Grady
Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

London

16 September 2022

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
16. Corporate Governance update

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☐	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☐	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☐	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☐	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☐	Ways of working ☐	Estates ☐
Communications ☐	Finance ☐	Operational and Clinical Excellence ☐	Governance and Compliance ☒
Other ☐ (please advise):			

What are the members being asked to do?		
Approve ☒	Note ☐	Discuss ☐

Report Author	Sarah Feal, Head of Governance
Date to which the information this report is based on was accurate	9th September 2022
Senior Responsible Owner	Maria Wogan, Chief of System Assurance and Corporate Services

Executive summary

Governance Handbook
On 29th July 2022, the Board of the Integrated Care Board approved amendments to the Board Committee's Terms of Reference and membership to those Committees. The Integrated Care Board's Governance Handbook has been revised to v2.0 and re-published, and is available from this link: https://bedfordshirelutonandmiltonkeynes.icb.nhs.uk/about-us/governance/

Committee Membership (Appendix A)
Appointments have continued to be made to finalise outstanding vacancies on Board Committees. An update to vacancies and appointments is provided on those memberships in Appendix A for Board approval. Once approved, the Terms of Reference for those Committee appointments will be updated in the Governance Handbook to reflect the new memberships.

Standing Financial Instructions (Appendix B)
Following implementation of the Standing Financial Instructions, in particular, the detailed schedule to operational / financial scheme of delegation, a minor operational amendment was requested regarding the process for issuing Single Tender Waivers, and attached for approval in Appendix B. A more detailed set of amendments to this schedule will be brought to the Board in November now all Executive appointments have been filled.

Constitution (Appendix C)
Following commencement of the Health and Care Act (2022) NHS England's legal team conducted a review of their model Constitution that was published by NHS England in May 2022 and identified several small amendments that need to be made. These are summarised in Appendix D and will be submitted to NHS England for formal approval week commencing 3rd October 2022 alongside some minor formatting amendments.

Committee Chair update (Appendix D)
Four Committees have met since the last Board meeting, and four were re-scheduled: one due to quoracy and three for falling within the period of National Mourning in September (Both Finance and Investment Committee and the Primary Care Commissioning and Assurance Committee on 9th, the Health & Care Senate on 14th and the Working with People & Communities Committee on 16th). The key highlights provided by the Committee Chairs from the meetings that have been held are attached in Appendix D including draft Minutes where these have been agreed with the Chair.

Terms of Reference (Appendix E)
No updates to Terms of Reference were requested by the Finance & Investment Committee when they met on 29th July 2022 nor the Bedfordshire Care Alliance on 18th August 2022.

As advised previously a revised Terms of Reference for the Working with People and Communities Committee (Appendix E1) was noted to be brought to the Board in September 2022. A revised Terms of Reference has also been recommended from the Primary Care Commissioning and Assurance Committee (Appendix E2). Both of these are attached.

What are the available options?

Approval of the Terms of Reference of the governance fora and amendments to the Standing Financial Instructions is a power reserved to the Board of the Integrated Care Board.

Approval of the Integrated Care Board Constitution is a power reserved to NHS England.

Recommendation/s

The members are asked to **approve** the following:

1) Appointments to Committee membership since 29 July 2022.
2) Summary of required amendments to Detailed schedule to operational / financial scheme of delegation.
3) Revised Terms of Reference for the Working with People and Communities Committee and the Primary Care Commissioning and Assurance Committee.

Members are also asked to **note** the following:

1) Summary of required amendments to the Integrated Care Board Model Constitutions Document.
2) Committee Chairs update including Minutes.

Key Risks and Issues

There are none identified.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

Not Applicable

Are there any financial implications or other resourcing implications?

There are none identified.

How will / does this work help to address the Green Plan Commitments?
Click to view Green Plan

Not Applicable

How will / does this work help to address inequalities?

Not Applicable

The following individuals were consulted and involved in the development of this report:

- Maria Wogan, Chief of System Assurance and Corporate Services
- Stephen Makin, Deputy Chief Finance Officer [Appendix D] and,
- Kathryn Moody, Director of Contracting [Appendix D]

Next steps:

The Governance Handbook will be updated and re-published on the Integrated Care Board website.

Appendices

Appendix A – Committee Membership Vacancies and Appointments
Appendix B – Amendments to Detailed schedule to operational / financial scheme of delegation
Appendix C – NHS England Constitution amendments
Appendix D – Committee Chairs updates including agreed Minutes
Appendix E – Terms of Reference for the Working with People and Communities Committee and Primary Care Commissioning and Assurance Committee

Appendix A – Committee Membership Vacancies and Appointments

Audit and Risk Assurance Committee
Vacancies update
There are none

Bedfordshire Care Alliance
Vacancies update
Primary Care Network Representative Central Bedfordshire – Outstanding vacancy

Finance and Investment Committee
Appointments update
One Non-Executive Member – Alison Borrett
One Non-Executive Member – Manjeet Gill

Primary Care Commissioning and Assurance Committee
Appointments update
One Non-Executive Member – Manjeet Gill

Quality and Performance Committee
Vacancies update
A member from the Health and Care Senate - Outstanding vacancy
Appointments update
One Associate Non-Executive Member – Lorraine Mattis

Remuneration Committee
Appointments update
One Non-Executive Member – Manjeet Gill
One Associate Non-Executive Member – Lorraine Mattis

Working with People and Communities Committee
Vacancies update
Non-Voting Member - One Healthwatch representative from Central Bedfordshire – Outstanding vacancy
A member from the Health and Care Senate - Outstanding vacancy
Appointments update
One Non-Executive Member (Chair) – Manjeet Gill
One Associate Non-Executive Member – Lorraine Mattis
One Partner Member Local Authority – Laura Church
One Partner Member NHS Trust / NHS Foundation Trust – Ross Graves

Health and Care Partnership
Vacancies update
Primary Care Networks a Clinical Director from: Central Bedfordshire

Appendix B – Summary of required amendments to the Detailed schedule to operational / financial scheme of delegation.

Amend references throughout from CCG to Integrated Care Board.

Page 137 amend the following statement from:

The Chief of Staff will issue documentation to be used to request any waiver under this clause, and record approval thereof.

Be amended to:

The Director of Contracting will issue documentation to be used to request any waiver under this clause, and record approval thereof.

Appendix C – Summary of Required Amendments to the ICB Model Constitutions Document

Following commencement of the Health and Care Act (2022) NHS England's legal team conducted a review of the model Constitution that was published by NHS England in May 2022 and identified several small amendments that need to be made.

These are summarised as follows:

- Section 1.4.7 (f) – Health and Care Act reference 'section 14Z44' corrected to read 'section 14Z45'
- Section 3.2.4 – Reference to the 'sections 56A to 56K of the Scottish Bankruptcy Act 1985' replaced with 'Part 13 of the Bankruptcy (Scotland) Act 2016'.
- Section 3.2.7 – 'A health care professional (within the meaning of section 14N of the 2006 Act)….'. First line updated to remove reference to section 14N of the 2006 Act and capital letters for 'Health Care Professional'. Line to read as follows 'A Health and Care Professional or other professional……..'.
- Section 7.1.1 – Reference to 'paragraph 11(2)' amended to 'paragraph 12(2)'.
- Appendix 1 – Add definition of 'Health Care Professional' to the table. Definition to be added: 'An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.'

Appendix D – Committee Chairs Updates

Finance & Investment Committee 29-07-2022
Update to Board on key points
▪ The Committee noted its Terms of Reference and discussed its annual work plan
Decisions for approval by the Board
▪ There are none

Bedfordshire Care Alliance 18-08-2022
Update to Board on key points
▪ The BCA Committee met for the first time in August 2022. ▪ This initial meeting was an opportunity to welcome new partner members not previously involved in the BCA and confirm governance arrangements including the process for disclosing and handling interests. ▪ The meeting noted that the Bedfordshire Care Alliance (BCA) Terms of Reference had been approved by the Board of the ICB at its meeting on 1 July, the Committee were asked to make any comments on these. No changes were proposed. ▪ It was noted that there would be a formal Committee effectiveness review in December 2022 and the Terms of Reference review would form part of this process. ▪ The main business of the meeting was to discuss the BCA's work plan and priorities and ways of working. It was noted that the work of the BCA needs to be rooted in supporting the key health and care challenges in Bedfordshire and underpinned by robust plans. ▪ Partners indicated that key priories in the BCA's work plan include developing a sustainable discharge model, supporting social care capacity including domiciliary care, dealing with post covid pressures including on children's services and waiting times, standardisation of the service offer to all Bedfordshire residents, supporting staff in post and improving recruitment, developing shared care records. ▪ These points will inform a stocktake of our 2022/23 work plan and be a starting point for the 2023/24 planning process which will be discussed at our next meeting in November 2022.
Decisions for approval by the Board
▪ There are none

Quality & Performance Committee 2-09-2022
Update to Board on key points
▪ The Quality and Performance Committee met on Friday 2 September. The committee's goal is to provide assurance to the board that the system's quality and performance goals are being met and that risks are managed. ▪ The committee discussed the new Patient Safety Incident Response Framework, being introduced by NHSE, and which we welcome as a well-designed and useful process. ▪ We reviewed performance across the system. The committee was impressed by the real-time data reported, which enabled us to see how the NHS parts of the system are performing. The NHS is facing severe operational pressures nationally and while our area is no exception, and our performance has been declining, on balance we are performing as well as other areas and our people are holding services together very well in difficult circumstances. ▪ The committee held a deep dive into aspects of care for Children and Young People, focusing on mental health provision. ▪ We also received reports on the maternity and neonatal system, transformation of care, and serious incident themes, and approved a Gamete Storage Policy. ▪ Overall, the committee concluded that it could take assurance that the information provided to the board on performance is accurate and not misleading, and that risks are properly identified and being managed – but within a background of severe operational pressures.

Quality & Performance Committee 2-09-2022
Decisions for approval by the Board
▪ There are none.

Audit & Risk Assurance Committee 2-09-2022
Update to Board on key points
▪ The Audit and Risk Assurance Committee held a constructive workshop on Friday 2 September on the process for managing system risk in BLMK. ▪ We set out a process for identifying, assessing and monitoring risks across the system, building on the work already done by the BLMK Clinical Commissioning Group in its handover to the ICB, the System Oversight and Assurance Group (which comprises the Chief Executives from NHS Trusts, Local Authorities and the ICB) and others. ▪ We discussed how to engage people across the system without having unwieldy meetings and asking for a lot of time from already busy people. ▪ Mindful of the need to focus on the key system risks, we set an aspiration to keep our highest level of risk summary to a single page, on the grounds that we ought to be able to recall our key risks from memory, and if there are so many that we can't, they probably aren't really "key". ▪ Given the work already done by system partners, and the need not to duplicate efforts, we set a process to review the risk registers already held across the system to identify the key risks and the work already being done to manage them, without requiring any new inputs or reports as an initial step. ▪ The ICB has a role to play in co-ordinating the management of system risks, and to encourage action at a system level (with system partners) where joined-up action is necessary and effective. ▪ We also have a role to identify those risks that cannot be adequately mitigated within the system and which need to be escalated to a regional or national level. ▪ Part of the goal of our system risk work is to build alignment on what are our top risks and what we need to do – that will allow us to communicate externally more powerfully because our message will be clear and consistent.
Decisions for approval by the Board
▪ There are none.

Attachments – draft minutes, approved by Chair:

a) Audit & Risk Assurance Committee – 15 July 2022
b) Bedfordshire Care Alliance Committee – 18 August 2022
c) Finance & Investment Committee – 29 July 2022
d) Health & Care Partnership – 4 July 2022
e) Health & Care Senate – 14 July 2022
f) Primary Care Commissioning & Assurance Committee – 8 July 2022
g) Quality & Performance Committee – 15 July 2022
h) Working with People & Communities Committee – 21 July 2022

Date: 15 July 2022

Time: 10.00 – 11.00

Venue: MS Teams

Minutes of the: Audit & Risk Assurance Committee

Members:		
Andrew Blakeman	Non-Executive Member, Chair	ABl
Alison Borrett	Non-Executive Member	ABo
Shirley Pointer	Non-Executive Member	SP

In attendance:		
Claire Baker	BDO Local Counter Fraud Service Manager	CB
Sarah Feal	Head of Governance	SF
Paul Grady	Grant Thornton External Audit Senior Manager	PG
Stephen Makin	Deputy Chief Finance Officer (deputising for Chief Finance Officer)	SM
Adam Spires	BDO Head of Internal Audit	AS
Justine Turner	BDO Senior Audit Manager	JT
Maria Wogan	Chief of System Assurance and Corporate Services	MW

Apologies from members:		

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the first Audit & Risk Assurance Committee (A&RAC) of the Bedfordshire Luton & Milton Keynes Integrated Care Board (the ICB). Apologies from members were received and noted as above. All in attendance introduced themselves and their role in relation to this Committee. The Chair confirmed that the members of the Committee are Alison Borrett, Shirley Pointer and himself (Andrew Blakeman), all of whom are Non Executive Members. All others attending the meeting are observers (attendees) of the meeting. The meeting was confirmed to be quorate.	
2.	**Relevant Persons Disclosure of Interests** Members were asked to confirm that all offers of Gifts and Hospitality received in the last 28 days had been registered with the Governance & Compliance team. There had been no submissions. Members were also asked to declare any relevant interests relating to matters on the Agenda and none were declared.	
3.	**Audit and Risk Assurance Committee Terms of Reference** The Terms of Reference (TOR) were approved by the ICB on 1 July 2022 and were presented for noting. Risk monitoring and escalation was discussed. The Chair clarified that individual risks are owned by parts of the organisation, that only risks that impact the system's commissioning obligations would be escalated to the A&RAC but that the risk process is owned by the A&RAC. It was agreed that there are two different types of system risk – aggregation of risks where more than one organisation is having the same issues, and interactional risk where one part of the system's problem affects another part of the system. The risk management process will evolve as we move forward and a short paper will be taken to the next meeting of the ICB on 29 July and the development of the risk management process will form part of the next Board Development session. The TOR proposed that Part 2 of the meeting would deep dive into one geographical area at a time, thereby relieving attendees from some of the meeting while enabling full and detailed discussion on one area. In time it might be beneficial to bring the areas together for a wider discussion and identify similar risks and interactions. The Terms of Reference were **noted**.	
4.	**Draft Committee Annual Cycle of Business**	

	The Annual Cycle of Business for Part 1 meetings which broadly looks at the Board Assurance Framework for the ICB as an organisation, was adopted. It was noted that risks in relation to the ICB's own activities will be looked at in Part 1, with attendees as today. It was agreed that a "Review of Committee Effectiveness" would be added to agendas for Part 1 in the early stages of the Committee (already a standing agenda item), and eventually become an annual review in March each year. Part 2 meetings would look at system risks – the register that aggregates and looks at the risks of interaction and to the system impacting its objectives. It would cover performance risks, including people and safety risks. This prototype register would need to be created, populated and a process agreed to manage the risks, including escalation to the Board of the ICB. The Part 2 meetings would include system participants as appropriate for the discussions. The paper that is going to the Board on 29 July will open the discussion as to how the risk register will be populated, managed and escalated to ICB as appropriate. **Action:** Any risks that remained on the Bedfordshire, Luton & Milton Keynes Clinical Commissioning Group (BLMK CCG) register will be moved onto the ICB register. It was agreed that the Risk Team will report back to this Committee in September following the ICB meeting on 29 July and their subsequent progress with this. **Action:** It was agreed to have a reduced attendance Part 2 of only the non-executive members in September, and then for the full complement of Part 2 system attendees to be invited from the December meeting.	**MW** **GF**
5.	**Internal Audit Annual Plan & Internal Audit Progress Report** BDO Senior Audit Manager introduced the Progress Report: - The 3 month plan for the CCG was delivered and reported to the last CCG committee; - Audit has commenced on Continuing Healthcare with outcome due to be reported to the September meeting; - Topical sector updates across a range of organisations are shared; - Work mandated by NHS England on improving financial sustainability is highlighted; and - Based on the HFMA checklist, an approach has been proposed and Terms of Reference have been shared with the Chief Finance Officer and System Finance Director for discussion. The Internal Audit Progress Report was **noted**. BDO Head of Internal Audit introduced the Internal Audit Plan: - There is a public sector requirement to pull together a 3-year audit programme each year, which will be refreshed annually; - There is flexibility to make adjustments or amendments;	

	- A large proportion of the plan is mandated by NHS England, particularly for primary care, commissioning key financial systems and the data security protection toolkit; and - The work required by NHS England & Improvement (NHSE&I), based on the work by Healthcare Financial Management Association (HFMA) regarding financial sustainability has also been built in. The Internal Audit Plan was **approved**.	
6.	**Local Counter Fraud Annual Plan** BDO Local Counter Fraud Service Manager introduced the Local Counter Fraud Annual Plan: - The plan was developed to bridge the transition from the CCG to the ICB and is brought to confirm that it is acceptable to the ICB; - Some actions have already been taken such as notifying the NHS Counter Fraud Authority of the ICB and the new responsible officers within the ICB; - A counter fraud risk register for the ICB is being developed – which will include prescription fraud and the security of prescription pads following a fraud case that was reported by NHS England, but which is now closed down. The Local Counter Fraud Service Annual Plan was approved.	
7.	**Local Counter Fraud Annual Report for the CCG** BDO Local Counter Fraud Service Manager introduced the report: - Annual reports to the Counter Fraud Authority do not strictly need to come to Audit Committee, but are shared for completeness; - The report will be signed off by the Chief Finance Officer; - The report contains the ratings against functional standards for the CCG, which are primarily green. The Local Counter Fraud Annual Report for the CCG was noted.	
8.	**Any Other Business** There was a brief discussion on committee effectiveness: - BDO liked the idea of rotating the attendance of representatives from different parts of the system to future meetings; - It is important regularly to review meetings; - Grant Thornton valued the discussion on risk which focussed on the process; - The classifications “aggregated” and “interactional” for risks were considered helpful and clear; - BDO liked the depth of discussion around place and the Bedfordshire Care Alliance; - It was a refreshing meeting and useful discussions; - Need to mindful of having a large agenda – agreed to consider the use of Chair’s Action or emailing for information, rather than all coming to Committee;	

	- Understanding exactly how the governance flows through the organisation will be key to the Committee's success; and - Need to make sure we pay attention to the right things.	
9.	**Date and Time of Next Meeting** The next meeting will take place on 2 September from 2-4 pm, via MS Teams. The meeting closed at 11.00.	

Approval of Minutes:		
Name	Role	Date
Andrew Blakeman	Chair	16-08-2022

Date: 18.08.2022

Time: 16.30

Venue: MS Teams

Minutes of the: Bedfordshire Care Alliance Committee

Members:			
Surname	Forename	Title	Initials
Pointer	Shirley	Chair, NEM BLMK ICB	
Carter	David	CEO Bedfordshire Hospitals	
Cox	Felicity	CEO BLMK ICB	
Kocen	Jane	PCN Clinical Director Bedford	
Ogley	Julie	Director of Social Care, Health and Housing, Central Bedfordshire Council	
Sunduza	Lorraine	Chief Nurse and Deputy CEO, ELFT	
Winn	Matthew	CEO, Cambridgeshire Community Services	

In attendance:			
Surname	Forename	Title	Initials
Blair	Alison	Programme Director, Bedfordshire Care Alliance	
Evans-Riches	Michelle	Programme Manager, BLMK ICB (Secretariat)	

Apologies from members:			
Surname	Forename	Title	Initials
Angel	Tammy	Clinical Director, Bedfordshire Hospitals	
Calaminus	Paul	CEO, ELFT	
Manjay	Barhay	PCN Clinical Director Luton	
Walker	Kate	Director of Adult Social Care, Bedford Borough Council	

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting. Apologies were received and noted as above. The meeting was confirmed as quorate.	
2.	**Relevant Persons Disclosure of Interests** Bedfordshire Care Alliance (BCA) Committee members had been sent Conflicts of Interest forms as it is a Committee of the Integrated Care Board (ICB) Board and, once returned the register will be updated. Members were also asked to declare any relevant interests relating to matters on the agenda and there were none declared.	

3	**Terms of Reference** The Bedfordshire Care Alliance (BCA) Terms of Reference were approved by the Board of the ICB at its meeting on 1 July, and the BCA Committee were asked to make any comments on these. It was noted that there would be a formal Committee effectiveness review in December 2022 and the Terms of Reference review would form part of this process. **Agreed: That there were no comments on the Bedfordshire Care Alliance Terms of Reference**.	
4	**Discussion on what the BCA should do to make the biggest difference to residents.** The Chair stressed that it was the responsibility of the members of the BCA Committee to be effective and efficient to improve the lives of residents in Bedfordshire. The Committee are accountable to and provide assurance to the ICB that actions being taken by the BCA are aligned to the priorities and values of the ICB and in doing so the BCA would listen to the voices of local residents. The following summarises the discussion: **General** • The Committee will focus on the things that only the BCA can do and reduce risk of duplication • There is a burning platform in acute care with the normalisation of current level of service pressures a concern. • The three Bedfordshire Councils plan and fund social care differently and are responsible to different government departments and this needs to be fully understood by BCA partners. • The requirement to bring together our perspectives to look at outcomes and reducing variation. • Identify preventative elements which we can collaborate on to ensure good quality of life. • Standardisation of outcomes and quality with some variation at place. • Focus on effectiveness first rather than efficiency. • Streamlining of sub-contracts, particularly with multiple organisations contracting with same providers. • how do we work with them and can it be more effective with other providers e.g. larger charities • Formulating recommendations to ICB regarding resource distribution. • Reducing inequalities and variation. **Social Care Capacity** • Hospital discharge fund solution is required, as there is no funding in 2023/24. • Collaboratively develop more radical, collective solutions to improve capacity. • Develop options for immediacy of discharge. • Models for long term domiciliary care need to be developed.	

- Social care means more than hospital admission avoidance, discharge, it includes areas such as inclusion, working with vulnerable people etc.
- There are immediate challenges for Councils e.g. need to look at fair cost of care requirements and other major challenges e.g. workforce, before we look at radical solutions.

Children's Services

- What we do to support high-cost care placements.
- Pressure on children's services due to pandemic and other issues which have impacted on demand.
- SEND and cost pressures.

Primary Care Access/Capacity

- Identify things that need to be done once across Bedfordshire.
- If primary care front door needs to be expanded the impact on estates and workforce which are currently constrained need to be examined and re-solved.

Hospital Services

- Standardisation across acute sites, Luton & Dunstable and Bedford Hospitals.
- Central Bedfordshire residents use a number of hospitals, not all of which are in BLMK and the ambition is to reduce inequalities.
- Patients are coming back into primary care whilst on waiting lists and conditions have to be managed. There is also the impact on primary care whilst patients are waiting for tests which limit diagnosis.

Community Services integration

- Providing a common unified affordable offer to residents.
- Provision of virtual wards this winter and expansion of provision next year.
- Identifying and providing frailty support for vulnerable people.

Mental Health

- Impact of pressures on other areas and supporting people with co-morbidities.

Workforce

- The impact of cost-of-living crisis on staff and challenge of recruitment and retention.
- New roles in primary care require mentorship and supervision.
- Maximising thinking and resources to unblock challenges.
- Understanding of gaps in our workforce, as the needs of our residents change.

Digital

- Minimising handoffs.
- Continue to develop the sharing data to make collective clinical decisions. The clinical portal will continue to be developed and will enable users to see whole individual will be enabler.
- Expand successful trials of digital interventions e.g. yellow bracelets.

	Agreed: 1. That the discussion points be used to inform a stocktake of the BCA's 2022/23 work plan and as the starting point for the 2023/24 planning process, to ensure there is focus on the most important priorities and work in a away consistent with our principles **2.That the Chair would contact the local authority members who were not present at the meeting to share what was discussed and asked for their perspective.**	**ACTION 1 AB** **ACTION 2 SP**
5	**Annual Cycle of Business** Noted	
6	**Any Other Business** None	
7	**Date and time of next meeting** • 17-11-2022 • 4.30-6pm, but investigations will be made to see if it can be extended. • If possible the meeting will be face to face and the venue will be confirmed. The deadline for papers will be • 8-11-2022	

Approval of Draft Minutes by Chair only:		
Name	**Role**	**Date**
Shirley Pointer	Chair	20/09/2022

Date: Friday 29th July 2022

Time: 14:00 – 15:00

Venue: Via MS Teams

Minutes of the: BLMK Finance & Investment Committee

Members:		
Name	**Role**	**Initial**
Alsop, Richard	Director of Commissioning, Contracting & Transformation	RA
Davies, Geraint	Director of Performance & Governance SIRO	GD
Makarem, Dr Rima	Chair	RM
Roberts, Martha	Chief People Officer	MR
Thomas, Mark	Chief Digital and Information Officer	MT
Westcott, Dean	Chief Finance Officer	DW
Whiteman, Dr Sarah	Chief Medical Director	SW

In attendance:		
Name	**Role**	**Initial**
Barnes, Nikki	Head of System & CCG Estates	NB
Feal, Sarah	Head of Governance	SF
Flynn, Gaynor	Governance & Compliance Manager	GF
Malciw, Alyson	Secretariat (Minutes)	AM

Apologies:		
Name	**Role**	**Initial**
Makin, Stephen	Deputy Chief Finance Officer	SM
Poulain, Nicky	Chief Primary Care Officer	NP
Murray, Anne	Interim Chief Nurse	AM
Wogan, Maria	Chief of System Assurance and Corporate Services	MW

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting. Apologies were received and noted as above. The meeting was confirmed as quorate.	
2.	**Relevant Persons Disclosure of Interests** Members were asked to review the Register of Interests [Appendix A] and confirm their entry was accurate and up to date, and to confirm that all offers of Gifts and Hospitality received in the last 28 days had been registered with the Governance & Compliance team. Members were also asked to declare any relevant interests relating to matters on the Agenda. There were none declared.	
3.	**Finance and Investment Terms of Reference** The Terms of Reference were discussed. NB referred to the section where it states major investment and dis-investment decisions needing to come to F&I Committee for review in the form of a business case. NB asked whether as we evolve there could be further definition around what would constitute a major investment or dis-investment decision in order that it is clear which business cases need to come to F&I Committee specifically. In response RM referred to the Standing Financial Instructions and SF confirmed that at the first Board meeting the Finance team set out delegated limits for the Directors and the Associate Directors. The PMO team are also drafting a Business Case process which will align with the Standing Financial Instructions, that will be coming forward once the Executive team have signed it off. The ToRs were approved and it was noted that they will be reviewed in 6-9 months time.	
4.	**Draft Committee Forward Planner** Items for the Forward planner were discussed and suggestions made:- DW suggested: December meeting – draft medium term Financial Plan update March meeting – draft Final plan for 23/24 RM suggested: A Dis-investment Policy, RA added that there is a Dis-investment platform, which although not fit for purpose will provide a platform to work to . DW mentioned the Red Pen Exercise, which is essentially a comprehensive budget review, which is in the Transformation paper. This has not been presented to the Executive Team yet, DW and RA to review. RM suggested: Successful bids and grants report. RA to take back to the PMO and ask about the Tracker for successful and non-successful bids. DW suggested a standing item regarding Transformation, for the Committee to track progress.	

	MR suggested the People Risk Register, RM agreed it would need to be included if there was a finance issue involved. SF added that for the December agenda she is aware that there is a project undergoing in the Organisation to look at the detailed Section 75 Agreements and in the Scheme of Reservation and Delegation it states that they are looked at by this Committee before they go to the Board. NB suggested Capital Pipeline for the ICS, we are expecting guidance to be issued in the Autumn about the development of an ICS Infrastructure Strategy, which would build upon the existing Estates Strategy that is in place. Time scale of meeting is unsure.	
5.	**Communications from the meeting** Approved the Terms of Reference and discussed the Forward Planner.	
6.	**Review of Meeting Effectiveness** ▪ **What key decisions did we make or what key outcomes did we arrive at to-day?** The Terms of Reference were reviewed and agreed.	
	Any Other Business The following items were raised: SF raised and confirmed that the review of effectiveness is planned as part of the internal audit plan and Committees are expected to complete this section.	
	Date and time of next meeting: 9th September 2022	

Approval of Minutes:		
Name	Role	Date
Dr Rima Makarem	Chair	[dd-mm-yyyy]

Date: 4 July 2022

Time: 10am

Venue: MSTeams

Minutes of the: Health and Care Partnership (ICP) held in public

Members:		
Name	Role	Initial
Councillor Tracey Stock	Chair	TS
Dr Manraj Barhey	Luton PCN Clinical Director	MB
Felicity Cox	ICB CEO	FC
Alison Davis	Milton Keynes University Hospital, Chair	AD
Emma De-Carteret	East of England Ambulance Director of Corporate Affairs and Performance	ED
Mary Elford	Cambridgeshire Community Services, Chair	ME
Javed Hussain	Luton Borough Council, Councillor	JH
Tracy Keech	Healthwatch Milton Keynes, Deputy CEO	TK
Rima Makarem	ICB Chair	RM
Peter Marland	Milton Keynes Council, Leader	PM
Sonal Mehta	VCSE Lead	SM
Mike Murphy	SCAS Executive Director of Strategy & Business Development	MM
Lucy Nicholson	Healthwatch Luton, Chief Executive	LN
Julie Ogley	Central Bedfordshire Council, Director of Social Care, Health and Housing	JO
Dr Navaneetha Rammohan	Milton Keynes PCN Clinical Director	NR
Eileen Taylor	ELFT Chair	ET
Helen Terry	Healthwatch Bedford Borough Chief Executive	HT
Kate Walker	Bedford Borough Council, Director of Adults' Social Care	KW

In attendance:		
Name	Role	Initial
Sanhita Chakrabarti	BLMK ICB Children and Young Peoples clinical lead	SC
Hilary Tovey	Assistant Director of Strategy	HT
Maria Wogan	Chief of System Assurance and Corporate Services	MW
Michelle Evans-Riches	Secretariat (Minutes)	ME-R

Apologies:		
Name	Role	Initial
Dorothy Griffiths	CNWL Chair	

Cllr Louise Jackson	Bedford Borough Council Chair of the Health and Wellbeing Board	
Dr Jane Kocen	Bedford PCN Clinical Director	
Cllr Khjtja Malik	Luton Council Portfolio Holder Public Health and Commissioning	
Cllr Hazel Simmons	Luton Council Leader	
Vicky Head	Bedford Borough, Central Bedfordshire and Milton Keynes Director of Public Health	

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the first meeting of the BLMK Health and Care Partnership (ICP). Apologies were received and noted as above. The meeting was confirmed as quorate.	
2.	**Relevant Persons Disclosure of Interests** Members were informed that the Conflict of Interest Management & Standards of Business Conduct Policy was approved by the ICB on 1 July and a conflicts of interest form would be sent to all members of the Health and Care Partnership for completion. Members were reminded that declarations of interest should be made as soon as reasonably practicable and by law within 28 days after the interest arises which could include an interest an individual is pursuing). Members were asked to declare any relevant interests relating to matters on the Agenda. There were none declared.	
3.	**Health and Care Partnership (ICP) Terms of Reference** The Health and Care Partnership (ICP) Terms of Reference were approved by the ICB meeting on 1 July and were presented to the joint Committee for noting. **Agreed:** **1. It was moved, duly seconded that Councillor Tracey Stock be appointed as Chair of the Health and Care Partnership.** **2. That the agenda setting group consider a nomination for the role of Deputy Chair and it would be reported to the next meeting for approval.** **3. That the delegated authority as detailed in paragraph 8.1 would be completed and reported to the next meeting.**	**Action1 TS Action 2 MER**
4.	**Integrated Care Strategy** The Health and Care Partnership had met informally on 28 March and 26 May when there had been engagement on the development of the Integrated Care Strategy.	

The strategy needs to define the ICS ambition for the next 10-20 years and focus on the purpose of the ICS of improving health outcomes, supporting sustainability and reducing inequalities.

The strategy would be developed over the summer, with community and partner engagement during the autumn and was required to be published by the end of December 2022. The strategy informed the Integrated Care Board's joint integrated care plan for the next 5 years which was required to be published by the end of March 2023.

The strategy will be informed by existing plans and strategies from partner organisations e.g. Joint Strategic Needs Assessments (JSNA), health and wellbeing strategies, place plans and insight from our people and communities. It will define how we work as a system, specify the case for change, and our population health ambition.

BLMK had already adopted system priorities and enablers which provided the framework for the elements in the strategy. There are three core stages to its development:

- Desktop review of all partners existing strategies and plans
- Review and forward view of population health data and system assets
- Engagement with partners, workforce and communities

Partnership members were asked to reflect on messages that have been shared so far for example the importance of inclusion of the wider determinants of health e.g. housing, employment, education and consider key measurements of success.

Data would be gathered from Place and Primary Care Network profiles including, Core 20+5 inequalities data, JSNA profiles and local insight. It was clarified that mental health data was included in primary care network profiles.

Key themes from community engagement to date were:

- Access to services, particularly primary care
- Information and communication
- Integrated working e.g. across schools, primary and secondary care
- Training for all staff on mental health awareness and dealing with people with compassion
- Personalised care
- Inequalities and inclusive services

<u>Discussion</u>

The strategy needs to reflect what partners are required to deliver, especially the statutory and contractual requirements.

The importance of communication with the community was stressed and to ensure engagement was maximised especially regarding prevention initiatives e.g. wellbeing checks.

Engagement was more effective if there is a small number of specifics that can be relayed to have an informed discussion on e.g. access to addiction services and how improving the experience in this area can be used as a model for other

	services. It was noted that there was some prioritisation in the Place Plans that need to be reflected in the strategy. The importance of thinking of a broad range of opportunities for example the experience the VCSE has working with groups and communities. The review of strategies and plans needs to include Buckinghamshire County Council. The importance of cultural competency and awareness of unconscious bias to ensure that the strategy and subsequent plan is inclusive of everyone in the community. The framework for making difficult decisions, particularly regarding financial investment when resources are stretched, was questioned. In response, it was noted that any changes to services or investment would have a quality impact assessment undertaken to inform the decision. National guidance was awaited for the 2 year operational plan, which was anticipated in the autumn and it was believed there would be a two year financial settlement which would assist in the planning process. It was emphasised that the strategy which covered the whole life course of our population was the responsibility of the joint Committee to develop and agree and the Integrated Care Board would work with partners on the NHS integrated plan to achieve the ambitions of the strategy. A number of partner organisations undertake quality improvement assessments as part of their service improvement agenda and this knowledge and expertise will be used to create and implement the integrated plan. The Partnership members were invited to respond to the following questions and the responses would be used to develop the strategy: 1. Are there any other specific groups or approaches we should be using to **engage our system partners** in the development of our strategy? 2. Are there any other specific groups or approaches we should be using to **engage our system workforce** in the development of our strategy? 3. Are there any other sources of data, or specific analysis you have under-taken, that you think we should be considering as part of this review? 4. Are there any other **key themes** or **specific groups** of our population that you think we should be considering as part of our review? 5. Are there any other **key themes** or **strategies and plans** that you think we should be considering as part of our review? The responses to the questions were captured in a Menti poll and would be used to develop the strategy. **Agreed: That the points raised in the discussion and responses to the specific questions be incorporated into the development of the draft Integrated Care Strategy which will be reported to the next meeting.**	**Action 3 HT**
	Communications from the meeting The Chair summarised the following:	

	The integrated care strategy will be developed from a variety of information sources including community insight, population health data, joint strategic needs assessments and local strategies Workshops will be held to understand and define the ambition of the partnership. The strategy will build on co-production and integrated working in BLMK.	
	Review of Meeting Effectiveness At each meeting members will be asked to comment on the effectiveness of the meeting, the information circulated in advance and any areas of improvement.	
	Annual Cycle of Business Partnership Board members were invited to put forward items for future meetings via the Committee Secretariat. **Noted**	
	Any Other Business None	
	Date and time of next meeting 21 September 2022 17:00 to 20:00 Central Bedfordshire Council, Priory House Chicksands SG17 5TQ	

Approval of Minutes:		
Name	Role	Date
Tracey Stock	Chair	20/07/2022

Date: **Thursday 14 July 2022**

Time: **1.00 – 2.00pm**

Venue: **Microsoft Teams**

Minutes of the: **Health and Care Senate**

Members:		
Name	**Role/Organisation**	**Initial**
Adam Staten	MK GP Federation Chair	AS
Angharad Ruttley	Acting Medical Director, ELFT	AR
Claire McKenna	Director of Nursing, ELFT MH	CMc
Emma Jones	Clinical Director - Community Services, CNWL	EJ
Ian Reckless	Medical Director, MKUH	IR
Paul Tisi	Medical Director, BHFT	PT
Pritesh Bodalia	Chief Pharmacist , BHFT	PB
Sally Cartwright	Director of Public Health, Luton Council	SC
Sarah Whiteman **(Meeting Chair)**	Chief Medical Director, BLMK ICB	SW

In attendance:		
Name	**Role/Organisation**	**Initial**
Christina Cannell	Executive Assistant / Secretariat, BLMK ICB	CC
Michael Ramsden (Item 4)	Associate Director of Planned Care, BLMK ICB	MR
Sarah Feal	Head of Governance, BLMK ICB	SF

Apologies:		
Name	**Organisation**	**Initial**
Anne Murray	BLMK ICB	AM
Anshu Rayan	CNWL	AR
Helen Chadwick	MKUH	HC
Helen Glyn-Davis	AHP Council	HGD
Helen Willets	CNWL	HW
Janet Thornley	Nurse Strategic Lead	JT
Julie Ogley	Central Bedfordshire Council	JO
Kate Howard	CCS	KH
Kate Walker	BBC	KW
Liz Lees	BHFT	LL
Nina Pearson	Primary Care/BLMK ICB	NP
Suraiya Chandratillake	ELFT	SC
Tayo Kufeji	Primary Care/BLMK ICB	TKU
Vicky Head	Bedford Borough, Central Bedfordshire & Milton Keynes Councils	VH
Victoria Collins	Milton Keynes Council	VC
Yolanda Bunga	CCS	YB

No.	**Agenda Item**	**Action**

1.	**Welcome, Introductions and Apologies:** The Chair welcomed members to the first meeting of the Health and Care Senate. Apologies were received and noted as above and the meeting was confirmed as quorate. SW advised that the purpose of the Health and Care Senate is a supportive, advisory body to the Integrated Care Board (ICB) to provide advice across the system.	
2.	**Conflict of Interest Management & Standards of Business Conduct Policy:** **Conflicts of Interest** Members were asked to declare any relevant interests relating to matters on the agenda. It was noted that PT and IR are Clinicians from providers included in the PCI Service review. It was noted that the view from the Senate will be comments/feedback on the report and service review generally, not provider specific. **Gifts and Hospitality** Members were asked to confirm if they have received any gifts or hospitality in the last 28 days in the capacity of working for the ICB, not their current NHS roles. No declarations were noted.	
3.	**Health and Care Senate Terms of Reference:** SW advised that the ToRs were approved by the ICB on 1 July 2022 however on further review the following changes were suggested: • **Membership:** Widening the membership of the Senate to include the LMC and the Local Pharmacy, Optometry and Dental Committees. The ICB doesn't currently commission these services however this will happen in the future therefore it would be useful to include that wider membership/view. • **Vice Chair role:** Suggested this is changed from the ICB Chief Nurse to the Director of Public Health for Bedford Borough, Central Bedfordshire and Milton Keynes Councils (Vicky Head). **The Health and Care Senate supported the suggested changes to the membership and Vice Chair role. It was noted that the agenda and papers would be circulated at least 5 working days before the meeting to allow members time to review and confirm attendance.**	**SW/CC**
4.	**Percutaneous Coronary Intervention (PCI) Strategy** **Context and Recommendation** *(as detailed within the report):* Percutaneous Coronary Intervention (PCI) is a minimally invasive procedure to open blocked arteries in the heart. It consists of a traditional 'Angioplasty' (using a balloon to stretch open a narrowed or blocked artery) coupled with a stent inserted into the artery. This stent remains in place permanently, allowing blood to flow more freely. This combination of angioplasty with stenting is known as PCI. PCI services in BLMK are not equally accessible with many residents needing to travel out of area for elective and non-elective PCI services. This has a negative effect on the patient experience, flow and the sustainability of services. SW advised that the majority of PCI services are currently delivered from Oxford and Bedford. Due to this a commissioner review of PCI services was commissioned. This is now complete and the report circulated provides some recommendations and a	

	preferred option: **Satellite Model of OUH at MKUH with an integration of services at Bedford and Luton & Dunstable Hospitals.** SW advised that the British Cardiovascular Intervention Society (BCIS) have been supportive of the proposal. **After a detailed discussion the following summary was agreed by the Health and Care Senate** *(post meeting).* **This will be fed back to the ICB ahead of the Board meeting on 29.07.22:** • The context of a commissioning review undertaken in response to a proposed new service to be provided by OUH at MKUH to be made explicit. • The language to be easier to understand with all acronyms spelt out in full at least once and explained. • Clear articulation of financial implications and timescales to be included if known *-[the financials are explicit within the paper. The start date is 01.12.2022 assuming agreement on 29.07.22].* • The main driver for the MKUH proposal was poor patient experience, particularly relating to longer lengths of stay (6 vs 2 days) associated with transfer of non-elective patients to BHFT or OUH currently. • Some concerns raised around de-stabilisation of BHFT services on Bedford and Luton sites, although both have a current workload that is less than national recommendations and some form of reconfiguration in Bedfordshire is both likely and desirable. • Workforce issues were discussed. MKUH expressed the view that the proposal would likely result in additional expertise and capacity coming into the ICS footprint rather than significant flux between units. Agreed that going forward and generically, workforce issues should be considered alongside proposals for change. • The issue of whether BLMK needs a Primary Percutaneous Cardiology (PPCI) Service (for people presenting with acute heart attacks) has not been addressed, although no members in the meeting aware of any specific concerns around current arrangements with the various tertiary centres with whom the hospitals currently link to (MK to Oxford, Bedford to Papworth and L&D to Harefield). A real or perceived problem with the status quo was a pre-requisite for such a development rather than an assumption that BLMK as a geography should provide a PPCI service. A PPCI review had been mooted as a future phase of this workstream, but re-considered in light of other pressures such as the need to reduce elective backlog. • Some concerns suggested regards lack of input from GIRFT leads, although the low likelihood of significance in the context of the evidence included (which referenced the 2021 GIRFT national report) and positive BCIS report (circulated to all) was noted. **The Health and Care Senate agreed and noted the response to the PCI Service Review.**	**SW**
5.	**Draft Committee Cycle of Business** The Health and Care Senate will meet a minimum of 2 times per year. It was noted that as the business of the ICB develops and progresses additional meetings can be convened as required. The Senate is not a statutory committee and meetings will continue to be held virtually. **The Draft Committee Cycle of Business was noted by the Health and Care Senate.**	

6.	**Communications from the Meeting** • PCI Strategy – View from the Health and Care senate to be fed back to the ICB ahead of the Board meeting on the 29.07.22.	**SW**
7.	**Review of Meeting Effectiveness** The Health and Care Senate were asked to feed back on the meeting effectiveness and if the discussion held addressed the questions asked. It was noted that some items will be more focused on specific areas e.g Acute, Primary Care etc however having the wider membership will enable that wider view and perspective to be included in discussions.	
8.	**Any Other Business** No items were raised. Mtg ended at 1.32pm.	
Date and time of next meeting: **Wednesday 14 September 2022,10.00 – 12.00 via MS Teams**		

Approval of Minutes:		
Name	**Role**	**Date**
Sarah Whiteman	Chair	
Health and Care Senate	Final Approval	

Date: 08.07.22.

Time: 1100-1142

Venue: MST

Minutes of the: Primary Care Commissioning & Assurance Committee (PCCAC)

Members:		
Name	Role	Initial
Borrett, Alison	Chair / Non-Executive Member BLMK ICB	AB
Makin, Stephen	Deputy Chief Finance Officer BLMK ICB	SM
Poulain, Nicky	Chief Primary Care Officer BLMK ICB	NP
Shah, Mahesh	Primary Medical Services Providers Partner Member BLMK ICB	MS
Turner, Phil	Chair, Healthwatch Luton	PT
Terry, Helen	Chief Executive, Healthwatch Bedford Borough	HT
Whiteman, Sarah (Dr)	Chief Medical Director BLMK ICB	SW

In attendance:		
Name	Role	Initial
Atkin, Kim	Committee Governance and Compliance Officer BLMK ICB	KA
Evans-Riches, Michelle	BLMK ICS Transition Programme Manager	MER
Feal, Sarah	Head of Governance BLMK ICB	SF

Apologies:		
Name	Role	Initial
Cartwright, Sally	Director of Public Health, Luton Council	SC
Cox, Felicity	Chief Executive Officer, BLMK ICB	FC
Head, Vicky	Director of Public Health, Bedford Borough, Central Bedfordshire & Milton Keynes Councils	VH
Keech, Tracy	Deputy CEO, Healthwatch Milton Keynes	TK
Kufeji, Tayo (Dr)	Primary Medical Services Providers Partner Member, BLMK ICB	TKU
Murray, Anne	Interim Chief Nursing Director, BLMK ICB	AM
Westcott, Dean	Chief Finance Officer, BLMK ICB	DW
Wogan, Maria	Chief of System Assurance & Corporate Services BLMK ICB	MW

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies (Chair)** The Chair welcomed everyone to the meeting. Mahesh Shah and Helen Terry introduced themselves to the Committee. Mahesh is a pharmacist operating from Luton for over 40 years and recently appointed to the ICB as a partner member representing primary medical services. Helen is the Chief Executive of Healthwatch Bedford Borough. Apologies were received and noted as above.	

	The Chair informed the committee that: - this was an initial meeting of the PCCAC to note terms of reference, discuss draft cycle of business, timelines for delegation of pharmacy, optometry and dental whilst also introducing the new format for ICB committee meetings - not all voting and non-voting members would join this meeting as ICB awaiting organisations confirmation of who they wish to attend - the meeting would be recorded for the purpose of the minutes - this was a private meeting and papers should not therefore be shared outside of this meeting unless you gain permission from the author - the meeting was confirmed as quorate.	
2.	**Relevant Persons Disclosure of Interests (Chair)** Conflict of Interest Management & Standards of Business Conduct Policy mentioned in the report will be shared with the Committee members as soon as possible but in the interim the Chair asked members: 1. to confirm their entry on the Register of Interests was accurate and up to date. All members confirmed entries were accurate and up to date. 2. to declare any relevant interests relating to matters on the Agenda. No interests were declared.	
3.	**Draft Primary Care Commissioning and Assurance Committee Terms of Reference (LD)** PCCAC terms of reference approved by the ICB on 01.07.22. All committees to review their terms of reference throughout the year and adapt as required. Members discussed and raised the following points: • *questioned the rationale around 'no deputies' specifically around voting which could limited effectiveness of the committee.* • *amendment required to 3.1 due to incomplete sentence:* The Committee exists to scrutinise ~~the robustness of to gain~~ and provide assurance to the ICB that there is an effective system of primary medical services commissioning. • *6.0. Responsibilities of the committee: queried if some of the operational responsibilities sat with PCCAC whose responsibility was to 'oversee commissioning of' and not to commission services which needs to be emphasised in terms (6.1. a)). These operational responsibilities are within scheme of reservation and delegation and standing financial instructions and sit with officers rather than PCCAC.* It was noted that some operational responsibilities may transition to sub-group committee being set up. LD confirmed the list would be reviewed (6.1 a-s) and moved as 'officers' work to the Executive led group which is focused on delivery. **Committee discussed and noted the terms of reference and subsequent actions agreed.** ACTION1: MER to confirm voting rights of deputies. ACTION2: amendment required to 3.1 due to incomplete sentence. ACTION3: Review responsibilities of the committee (6.1). ACTION4: Review of TOR to be scheduled on cycle of business. ACTION5: TOR for sub-group delegated from PCCAC to be agreed.	 MER SF LD LD LD
4.	**Timeline for transition of delegated functions to the ICB in 2022 and 2023 (LD)** High level summary presented of work taking place with ICB, NHSE regional team and other system partners:	

	- CCG was in delegated commissioning arrangement for the 96 Primary Medical Services (GP) contracts since 2017/18. - signed new national delegation agreement to continue with commissioning of GP contracts from 01.07.22. on transition to the ICB. - working through transition of pharmacy, optometry and dental (POD) services and NHS complaint functions from April 2023. - national delegated agreement for PMS prepared for pharmacy, optometry and dental but will not be signed until circa March 2023 to allow time to receive. - The ICB will be required to work through the development of a Pre-Delegation Assessment Framework (PDAF) with NHSE. - significant number of contracts to be delegated in April 2023 - Community pharmacy contracts: 163; Optometry contracts: 86; Dental contracts: 148. BLMK ICB may directly hold those contracts or agree a hosting arrangement with regional system partners, i.e. one ICB hosts contracts on behalf of other ICBs. Agreeing these arrangements are part of programme being worked through at regional meetings and include assurance, finances/budgets and staffing to support future arrangements. Pre-Delegation Assessment Framework (PDAF) process is the tool used to provide assurance. - PCCAC will receive regular reports up to March 23 which is the target date. Members raised following questions/points: • *LD to send MS and members a visual of the various PMS contracts and numbers.* • *LD explained that ICB hold GP contracts and will be holding dental but pharmacy and optometry may be hosted by one ICB (six ICBs in EoE region) on behalf of the other five.* • *Architecture for complaints function will not change until April 2023; number of NHSE complaints staff in region small due to large capacity via 'contactus' in Redditch. Working through if function to be hosted to ensure subject matter experts are retained or whether ICB take its own complaints.* • *Questioned what would happen through PDAF process if ICB (or ICBs collectively) declared they were unprepared or unwilling to take on delegation from April 2023?* Commitment made from six ICBs to take on delegation but arrangements to be decided; each function will be reviewed and worked through. NP suggested value of having central complaints function to enable ICBs to see totality of issues/pathways and link to PHM work. ICBs in EOE also committed to work collaboratively. • *SM questioned if community and acute dental were being considered by this committee for delegation and was it in the committee's remit to do so (noting significant risks with commissioning those services due to long waiting lists)?* LD/NP confirmed that community dental and acute dental would be in scope of PCCAC who would have oversight of this as a sub-committee of the Board. **Committee noted the update and timelines for transition of delegated functions to the ICB in 2022 and 2023.** **ACTION6: LD to circulate visual overview of contracts the ICB will hold from April 2023.**	LD
5.	**Draft Committee Cycle of Business (LD & NP)**	

	Draft cycle of business reflected work being undertaken and what is anticipated to be presented to PCCAC for assurance in 2022-23. This will include the large programme of procurement, review and refresh of strategies and quality and performance reports. Members were asked for feedback and any additional business to be added. - *NP noted overlaps of business and reports to the committee e.g. (i) primary care digital overlaps with wider digital strategy (SW SRO) but PCCAC would be assured on how primary care digital was driving transformation; (ii) estates (DW SRO) would be showing how primary care drives and enables system ambitions.* - *cycle of business was a live document and would be a standing agenda item to ensure complete oversight and input from members.* - *noting the number of items for assurance the Chair questioned length of meeting and suggested this be reviewed after two meetings (added to business cycle).* **Committee noted draft cycle of business and that it would be a standing item.**	
6.	**Communications from the meeting (MER)** Committee informed this would be a standing agenda item with a member of communications team attending to identify (with Chair's direction) the key pieces of information to go out to ICB, partners and the public. All meetings will be held in public. • *PT and MS raised lack of awareness of both public and health professionals of what primary care commissioning, the ICS and ICB etc. were.* • *PT suggested communications via PCN Clinical Directors to PPGs.* • *NP advised need to work through how using Place Boards to recognise what was important to residents in each place and how to work collectively to address these and share communications. Part of recommendations of Fuller stocktake was resilient excellent primary care at the heart of all communities (https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/). NP to share previous slides with MS.* • *Identify communications and determine 'who does it need to be shared with and for what purpose?'* **Committee noted as new standing item on agenda.**	
7.	**Review of Meeting Effectiveness (MER)** Committee informed this would be a standing item at each meeting. ICB formal review of effectiveness to be held at six months and this item would provide evidence of continuous opportunity for members to comment. Standard questions to be agreed with the Chair and used to structure feedback. • *PT supported its inclusion and suggested statement outlining purpose of the committee at the beginning of the meeting.* • *LD confirmed to the Chair that how the sub-group would feed into PCCAC was being worked though. Advised that under NHSE you can now double delegate which PCCAC would do to the sub-group to ensure the Committee receives high level assurance and not day to day operational items.* • *MER confirmed to HT that papers and minutes would be on the public website.* **Committee noted as new standing item on agenda.**	

	ACTION7: Chair to advise attendees of the purpose of committee at beginning of each meeting. **ACTION8: Add committee to public website for papers and minutes.**	Chair MER
8. 8.1	**Any Other Business** MER confirmed to MS that the Committee would review frequency and timings of committees as part of the ICB's six-month formal review of effectiveness, but reiterated that this was an 'assurance' committee of the board and operational issues would be delegated to its sub-group.	
9.	Date and time of next meeting: 09.09.22. 1400-1600 via teams	

Approval of Minutes:		
Name	Role	Date
Alison Borrett	Chair	11.07.22.

Date: Friday, 15 July 2022

Time: 11:00 – 12:00

Venue: MS Teams

Minutes of the: Quality and Performance Committee

Members Present:		
Name	**Role**	**Initial**
Andrew Blakeman	Chair	AB
Maria Laffan	Deputy Chief Nurse	ML
Martha Roberts	Chief People Officer	MR
Mahesh Shah	Partner Member, Primary Medical Services	MS
Maria Wogan	Chief of System Assurance and Corporate Services	MW

In attendance:		
Name	**Role**	**Initial**
Sarah Feal	Head of Governance	SF
Beverley Husbands	Secretariat (Minutes)	

Apologies:		
Name	**Role**	**Initial**
Anne Murray	Chief Nurse	AM
Sarah Whiteman	Chief Medical Officer	SW

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** • The Chair welcomed everyone to the meeting. • Apologies were received and noted as above. • The meeting was confirmed as quorate. • The Group was advised the meeting is being recorded	
2.	**Relevant Persons Disclosure of Interests** 2.1 Members were asked to confirm that all offers of Gifts and Hospitality received in the last 28 days had been registered with the Governance & Compliance team. 2.2 Members were also asked to declare any relevant interests relating to matters on the agenda. There were none declared.	
3.	**Quality and Performance Committee – Terms of Reference** 3.1 AB advised the Terms of Reference were approved by the Integrated Care Board and brought to this group to note. AB asked the group if there were any comments, issues or corrections to be acknowledged. The group accepted the Terms of Reference with the recognition that they may need revision when appropriate to do so. 3.2 MW asked the committee to re-examine the group's membership with a view to ensuring the professional attendance is more balanced. It was noted that a fourth non-executive will be appointed in due course as well as one associate. 3.3 AB advised it would be beneficial to include an independent, clinical professional in the committee's membership to provide clinical input when required. SF confirmed a clinician from the Health and Care Senate was recently nominated to attend this committee. 3.4 AB confirmed MS is the Primary Medical Services Partner and will be the deputy chair. Appointment of a member from the Health and Care Senate is imminent.	
4.	**Group Discussion** 4.1 AB asked the group to consider the committee's remit [1]Elevator Pitch, i.e., what is the purpose of this committee and what does it hope to achieve, for the Board, the Bedfordshire, Luton and Milton Keynes system and local communities at each place (Bedford, Central Bedfordshire, Luton, Milton Keynes). Each attendee was asked to give their thoughts on the mission of the committee. 4.2 SF – the committee is responsible for providing assurances that commissioned services are safe, well-led and that residents have a positive experience of the service they receive 4.3 ML – referred to Section 6 of the Terms of Reference (ToR) i.e., "*the Quality and Performance Committee will develop an approach to assurance in partnership with NHS Trusts, Foundation Trusts, primacy care providers and other health and care providers operating in BLMK*…" ML noted the group would not be responsible for providing assurance but would be responsible for the approach taken to gain assurances that services are safe, effective and that people have a good experience 4.4 MW clarified that the ICB is not a provider but here to help manage the system and quality assure the effectiveness of services. With regard to the elevator pitch, performance reports will identify whether people are able to access and	

[1] A brief and concise speech that tells about who you are, what you do, and what you want to achieve. It should be short and compelling enough that you can introduce yourself during an elevator ride.

No.	Agenda Item	Action
	receive good quality care in a timely fashion. Ensuring equality measures are met is also a responsibility of this committee 4.5 AB summarised the mission as safe, well-led, clinically effective/efficient, positive patient experience, timely, accessible, i.e., equitable – equal access for all 4.6 AB noted the ICB has a statutory duty to monitor and supervise commissioned providers, there is also a system responsibility to monitor service provision in our local areas 4.7 MR suggested the group look at examples of good practice, in line with the five strategic priorities which should be included in the Elevator Pitch 4.8 ML – noted the section 6.2 of the [2]ToR and the need to ensure there is no duplication in the function of the committee. Well-Led is an area that is inspected and reported on by the Care Quality Commission (CQC), this is evidence we can access and include when looking at assurances across the system. We will be able to feed into / get feedback from the System Quality Group (SQG) and there is a process for regional escalation, where indicated. 4.9 AB clarified - CQC assesses whether commissioned providers are well-led. As an ICB, we are responsible for ensuring this group is well-led. We have a System Quality Group that feeds into this committee, the committee can escalate directly to the Board who can then escalate regionally 4.10 MS – The Elevator Pitch should address all stakeholders across health and social care, and include service feedback from members of the public 4.11 AB - the committee needs to be able to clearly articulate and have a clear understanding of its Elevator Pitch first, before it can be shared more broadly 4.12 MR - What about [3]VCSE and social care? There are some social care services that are not regulated by the CQC. The ICB will fall under CQC regulation. We do need to carefully work things through to ensure equity in the four places in recognition of the differences in each area. It was suggested that examples of good practice/good outcomes should be explored 4.13 AB – summary of conversation to aid in preparing a statement for the direction of the committee – This committee will provide assurances to the board that commissioned services are: • Safe • Effective • Well-led • Give a positive patient / service user experience • Aligned with the ICB's five strategic priorities, (Start Well, Live Well, Age Well, Growth and Reducing Inequalities) • Timely • Equitable The scope of the system includes health and social care stakeholders as well as the VCSE sector and other care providers, the idea of places and the concept of subsidiarity. The committee has two roles, that of supervisor through the authority given to us via NHS England to supervise and monitor commissioned services as well as a new duty to bring the whole system function together and provide assurances that the system is working well as a whole. We will receive information from the System Quality Group, and we have established escalation routes	

[2] Terms of Reference
[3] Voluntary organisations, Community Groups & Social Enterprises

No.	Agenda Item	Action
	4.14 AB asked for examples of how this committee would respond to adverse information about a provider. 4.15 ML - National expectation of what the service should look like, local position on current issues, mitigations, escalations, opportunities to make improvements. 4.16 AB – Providers - The committee's role would be to see problems early (evidenced in reports/data provided), ensure there are robust plans to address any issues along with appropriate system communications /system responses, appropriate escalation and to look for opportunities for partners to work together to make improvements. The committee should ensure that the Board receives an accurate report of any system issues as well as robust risk management and mitigation plans. 4.17 MS – the committee should try to take a proactive approach, e.g., with the use of a dashboard and [4]KPI's which will give lead indicators of themes and trends and allow earlier intervention 4.18 AB- advised there is a list of metrics developed by NHS England for the ICB to use as a monitoring tool and deferred to MW. 4.19 MW advised as part of a current a programme of work, one of the key objectives for the performance team is developing a dashboard with accurate information that can be used to prepare and shape reports. During a recent audit committee there was discussion about system risks and how endorsed risks are to be reflected on the risk register. It's anticipated that the work of this committee will include looking at identified system risks that relate to Quality and Performance issues. 4.20 MS – is it possible to benchmark performance indicators as well as use [5]AI to produce relevant data and show trend analysis. ML noted it is important to recognise the importance of the patients that sit behind the data.	
5.	**Quality and Performance Committee Annual Cycle of Business** 5.1 AB noted the Performance and Quality Report, and the Quality Risk Register will be core products that feed into the Quality and Performance Committee. 5.2 The group advised it is also important to be aware of regulatory inspections and outcomes, complaints, consider whether to have an audit programme or ad hoc system deep dives. Noted there is a new patient safety framework, Patient Safety Incident Response Framework [6](PSIRF) which replaces Serious Incidents and Never Events management tools 5.3 ML noted some of the system deep dives have been happening under the auspices of the System Quality Group; these can be fed into this committee; ML will have a conversation with Anne Murray for further information and clarification and report back to the group. 5.4 Next meeting to be three hours to allow time for discussion of all agenda items; all agreed, for the time being, meetings will be conducted via MS Teams with the option to have hybrid meetings	**ML**
6.	**Communications from the meeting** 6.1 Elevator pitch to be refined and brought back to next meeting	**AB**

[4] Key Performance Indicators

5 Artificial intelligence

[6] The NHS Patient Safety Strategy (July 2019) recognises the importance of involving patients, their families and carers and other lay people in improving the safety of NHS care, as well as the role that patients and carers can have as partners in their own safety. This framework sets out how NHS organisations should involve patients in patient safety.

No.	Agenda Item	Action
	6.2 Seek members from Trusts and other partner organisations to become regular attendees	
7.	**Review of Meeting Effectiveness** 7.1 SF – very useful discussion, however it is important for the secretariat to be clear about any actions and responsibility for those actions to be recorded at each section of the meeting 7.2 MR – useful to understand how the work of the committee is communicated through to other colleagues in the hospital and the rest of the Trust and vice versa to promote system connections and working together 7.3 MS – the meeting was very efficient but think about allowing more time to conduct committee business 7.4 MW – more space in the meeting for developmental conversation and sharing perspectives, would support additional time for the committee meetings to help build the right approach	
8.	**Any Other Business** The following item was raised: 8.1 MS queried whether a deputy could be nominated to attend on a member's behalf. It was clarified that this is permitted but the deputy would have to be a member of the Integrated Care Board in a similar professional capacity, i.e., a Partner Member of Primary Medical Services or Non-Executive Member, etc., and be fully briefed before attending the meeting. The Chair must also be aware of who will be serving as a deputy before the meeting. 8.2 AB thanked all attendees for their input and closed the meeting	
	Date and time of next meeting **Date**: Friday, 02 September 2022 **Time**: 10:00 – 12:00 **Via**: Microsoft Teams	

Approval of Minutes:		
Name	**Role**	**Date**
Quality and Performance Committee	Final Approval	02/09/2022
Andrew Blakeman	Chair	08/08/2022
Sarah Feal	BLMK Head of Governance	27/07/2022

Meeting closed 12:01

Date: 21st July 2022

Time: 10 – 11am

Venue: MSTeams

Minutes of the: Working with People and Communities Committee

Members:		
Name	Role	Initial
Alison Borrett	Chair	AB
Mahesh Shah	ICB Primary Medical Services	MS
Maria Wogan	ICB Chief of System Assurance and Corporate Services	MW

In attendance:		
Name	Role	Initial
Sarah Frisby	ICB Head of System Engagement	SF
Anona Hoyle	ICB Senior Engagement Officer	AH
Karen Ironside	Transitions UK - VCSE	KI
Jane Meggitt	Director of Communications and Engagement	JM
Maxine Taffetani	Healthwatch Milton Keynes	MT
Helen Terry	Healthwatch Bedford	HT
Michelle Evans-Riches	Secretariat (Minutes)	MER

Apologies:		
None		

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the first meeting of the Working with People and Communities Committee. There were no apologies for absence received. The meeting was confirmed as quorate.	
2.	**Relevant Persons Disclosure of Interests** Members were informed that the Conflict of Interest Management & Standards of Business Conduct Policy was approved by the ICB on 1 July and a conflicts of interest form would be sent to all members of the Working with People and Communities Committee for completion. Members were reminded that declarations of interest should be made as soon as reasonably practicable and by law within 28 days after the interest arises. Members were asked to declare any relevant interests relating to matters on the agenda. There were none declared.	
3.	**Working with People and Communities Committee Terms of Reference (TOR)** The Working with People and Communities Committee Terms of Reference were approved by the Integrated Care Board (ICB) at its meeting on 1 July 2022. As the ICB is a new organisation and way of working, members were asked for comment on the terms of reference and any changes can be recommended to the ICB. The ICS vision is "for everyone in our towns, villages and communities to live a longer, healthier life" and it was suggested that this could be broadened to include happy/happier lives, and therefore encompass not just physical, but mental health. As this is the ICS vision, this would feedback could be considered as part of the development of the Integrated Care Strategy by the Health and Care Partnership which has this responsibility. There will be wider partner and public engagement on the Integrated Care Strategy in the autumn. MT had made several comments and suggestions on the terms of reference and had submitted them in writing in advance of the meeting which included: • The four core principles of the ICS (below) be included in the TOR to ensure that these were considered as part of any discussion at the Committee: 1. Improving outcomes in population health and healthcare 2. Tackle inequalities in outcomes, experiences and access 3. Enhance productivity and value for money 4. Help the NHS support broader economic development • All four Place Healthwatch representatives be included as voting members on the Committee.	ACTION 1 MER

	• Regular participants of the Committee – there was an extensive list in the ToR and this could complicate the structure and effectiveness of meetings and if adopted would need a well-planned structure. • Enable all members to have deputies, rather than those explicitly allowed in the TOR. • Clarification on the role of the Committee in providing assurance to the Integrated Care Board and how this will be achieved • The Committee to develop a work plan to measure effectiveness. A report was being produced for the ICB meeting on 29 July on comments from the Committees on their respective TOR. However, due to the timescale of papers being circulated for the ICB it was proposed that the amendment to the membership for the four Place Healthwatch representatives be put forward and the remaining changes would be circulated for the Committee to review, before being referred to the Board of the ICB in September. It was clarified that deputies were permitted and should only attend the Committee in exceptional circumstances, with prior notification to the Chair. The cycle of business/work plan would be a standing item on the agenda for the Committee to discuss future items of business. It was also explained that voting at Committees happened infrequently and if the vote was a tie, the Chair had the casting vote. It was emphasised that any report on engagement should detail the measures undertaken and provide data on the effectiveness of the engagement to provide assurance to the ICB and share learning. **Agreed: 1. That the ICB be recommended to amend the membership of the Working with People and Communities to include the four Place Healthwatch representatives as voting members.** **2. That the TOR be reviewed considering the comments received, and a revised TOR be circulated to the members for review prior to revised ToR being presented to the next meeting and then onwards to the Board for approval on 30 September 2022.**	ACTION 2 MW ACTION 3 MW/MER
4	**Working with People and Communities Strategy and Policy** The Integrated Care Board (ICB) approved the Working with People and Communities policy at its first meeting on 1 July. It is fundamental to the new ways of working of the new organisation. This policy will be kept under review as the working of the ICB and system develops. NHSE has published guidance and some principles on how ICS should work with people and communities and Healthwatch in BLMK have been instrumental in developing the thinking on how to engage effectively with our residents and communities. A draft working with people and communities' strategy has been sent to NHSE for feedback and, once received, this will be used to further enhance the strategy.	

	The draft strategy builds on the collaborative work undertaken with system partners particularly during Covid. It is recognised that there will be a period of transition and an implementation plan and robust infrastructure will need to be put in place to ensure that engagement mechanisms are effective. The final strategy will be reported to this Committee in September and will be recommended to the ICB for approval. There is already a plethora of data and information, but there is no formal mechanism to capture and anaylse this at a system or place level. Therefore, an insight bank is being established to capture rich qualitative information on services. This was welcomed as community pharmacists, general practices, community teams etc. all collected relevant information on residents and families. The insight bank would be a platform with a wide range of users and partners will be asked to test the site. Training will be provided to ICB staff and partners on how to undertake meaningful engagement. Healthwatch Milton Keynes recognised the challenge of public engagement and establishing interest in the strategy, and there was a need to build trust with the residents. It needs to be explicit on what will change as a result of the engagement and the strategy, and the Committee had a key role in overseeing this. MS extended an offer to undertake health campaigns in the local community and this could be expanded to provide localised targeted engagement and communication. The draft strategy referred to GDP and the number of working people in BLMK and this information will be checked for accuracy. The Health and Care Partnership was responsible for establishing the Integrated Care Strategy and the ICB was responsible for the delivery of the 5-year plan that underpins the strategy. It was essential to link the working with people and communities work to the development of the strategy and plan, and it was helpful that the communications and engagement and programme management teams were both in the same directorate and will share information. **Agreed: 1. That the Working with People and Communities Policy be noted. 2. That the draft Working with People and Communities Strategy continue to be developed, taking into account comments made in the meeting and be reported to the next meeting of Committee for consideration before submitting to the ICB for approval.**	ACTION 4 JM ACTION 5 JM
5	**Draft Committee Work Programme** A draft Committee cycle of business was included in the agenda for comment. This will be a standing item on the agenda to ensure that members had input into future Committee agenda and that there is appropriate planning for items that could require specific interest or community groups to be invited. **Agreed: That the following items be added to the work plan for the next meeting:**	

	1. **Working with People and Communities Strategy and implementation plan** 2. **Integrated Care Strategy engagement plan** 3. **Revised Committee Terms of Reference**	ACTION 6 AH
6	**Communications from the meeting** Key items for communicating with the ICB workforce, ICS partners and or public will be highlighted. The key messages from this meeting were: • Welcomed comments on the Committee Terms of Reference and a revised TOR will be circulated to members for comment, prior to consideration at the next Committee. The ICB on 29 July will be recommended to include the four Place Healthwatch representatives as voting members of the Committee. • The progress on the working with people and communities' strategy was noted and the final strategy with the implementation plan will be reported to the next meeting. • Engagement on changes to the Percutaneous Coronary Intervention (PCI) service provision in Milton Keynes was being considered at the ICB on 29 July. Members were informed that there may be instances whereby service change consultation and engagement was circulated to the committee outside meetings if there was not an appropriately timed committee meeting.	
7	**Review of Meeting Effectiveness** As part of the arrangements for the development of the ICB and Committees, members will be asked a series of questions to evaluate the effectiveness of the meeting and identify any improvements that can be made. This will be standing agenda item.	
8	**Any Other Business** The following items were raised: 1. **Percutaneous Coronary Intervention (PCI) service** Members were advised that a report was being considered at the ICB on 29 July regarding a proposed service change to the Percutaneous Coronary Intervention (PCI) in Milton Keynes. Initial engagement had taken place with service users who currently travel to Oxford, Bedford or Luton for this treatment. The proposal was to provide PCI service locally at MKUH and this would not de-stabilise the service provision in Bedfordshire Hospitals. Further engagement on the proposed change to the patient pathway to deliver it more locally would take place and discussions were underway with the local authority Overview and Scrutiny Committees to agree on the approach. 2. **Head and neck services Milton Keynes** Members were informed of the future engagement on a proposed service change to head and neck cancer service for Milton Keynes residents which is currently provided in Northampton.	

	It was noted that, on occasions where a decision was time critical, there may be a need to circulate information on proposed service changes electronically to the Committee members. **Noted**	
	Date and time of next meeting 16 September 2022, via MST 10am – 12pm	

Approval of **DRAFT** Minutes:		
Alison Borrett	Chair	01-08-2022

Working with People and Communities Committee Terms of Reference v2.0

1.0 The Committee

1.1 The Working with People and Communities Committee (the Committee) is established by the Integrated Care Board (ICB) as a Committee of the Board of the ICB (the Board) in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is a non-executive chaired Committee of the Board, and its members are bound by the Standing Orders and other policies of the ICB.

2.0 Role and Responsibilities of the Committee

2.1 The Committee shall:

- ~~Give~~ Develop a detailed work plan to provide assurance to the ~~Integrated Care Board~~ ICB that ~~the Integrated Care Partnership (ICP) is involving~~ citizens will be involved in decisions ~~around~~ on the planning and delivery of health and care services in Bedford Borough, Central Bedfordshire, Luton and Milton Keynes, in line with the Working with People and Communities policy ~~enshrined in the Constitution~~ in order to deliver the ICS core purposes of:

a. Improving outcomes in population health and healthcare
b. Tackle inequalities in outcomes, experiences and access
c. Enhance productivity and value for money
d. Help the NHS support broader economic development

- . Oversee the delivery and evaluation of the work plan and report to the ICB on the outcomes of citizen engagement.
- ~~To work with commissioners and system partners across the Integrated Care Partnership to understand what transformation programmes are being undertaken, as part of the five ICP priorities, and produce a workplan to ensure that the Board has oversight and assurance that appropriate and proportionate participation is observed in line with policies.~~
- Work with Integrated Care System partners to ensure citizens are engaged with, listened to and co-design health and care services at ICS, Place and Care Alliance.
- Advise and provide assurance to the ICB on planning, delivery, outcome and evaluation of statutory consultation.
- Work with the secretariat and executive members to ensure it receives timely, high quality information in a format that supports the delivery of the functions.

3.0 Functions

3.1 The Committee shall:

- Advise and provide assurance to the Board that there is ~~they have an~~ an appropriate ICB work plan to support the statutory duty to consult hearing the voice of citizens in everything it does.
- Have oversight of the planning and delivery of the public engagement and communication ~~Provide assurance over the delivery of the annual~~ work plan and to report to the ICB on the evaluation and outcomes of citizen engagement
- Ensure that appropriate plans ~~steps are being taken~~ are in place to include the voice of citizens and people with lived experience from Bedford Borough, Central Bedfordshire, Luton and Milton Keynes into decision making for transformation programmes, service development and improvement at scale, place and neighbourhood.
- ~~Review plans to involve citizens in all work being undertaken across the Integrated Care Partnership and provide assurance to the Integrated Care Board that local voices are being incorporated into all transformation programmes, in line with statutory requirements.~~
- ~~To assure the Integrated Care Board that the ICP is delivering against the ten principles as outlined in the Working with People and Communities guidance, as published by NHS England.~~
- To ~~regularly~~ review annually the ICB's working with people and communities policy and strategy to ensure it reflects best practice and recommend amendments to the Board of the ICB for approval.
- Provide feedback to commissioners, partners and workstream leads on engagement, consultation and co-production to provide assurance to the Board on the planning, delivery and evaluation in line with the principles set out in the Working with People and Communities policy and NHSE guidance..
- ~~Ensure lived experiences are used to support service development and improvement.~~
- Contribute to the delivery of patient and public engagement related reporting requirements including, but not limited to, the ~~Integrated Care Board~~ICB's annual reports and accounts.
- Deliver any functions delegated to it under the ~~Integrated Care Board~~ICB's Scheme of Reservation and Delegation.

3.2 The Committee shall also:

- Support such activities as are necessary for the Committee to support for the delivery of Bedfordshire, Luton and Milton Keynes ICB.
- Oversee those functions relating to patient and public engagement that the responsibility of the ~~Integrated Care Board~~ICB.
- Deliver any other functions delegated to it by the ~~Integrated Care Board~~ICB.
- Oversee the analysis and sharing of insights and themes emerging from

citizen engagement and other feedback mechanisms.
- Assure the ~~Integrated Care Board~~ICB's response to local or national consultations.

4.0 Composition and Membership

4.1 The voting membership of the Committee shall be:

- Non-Executive Member or their nominated deputy (Chair).
- Non-Executive Member or their nominated deputy (Deputy Chair).
- The Chief of Assurance and Corporate Services or their nominated deputy.
- One NHS Trust/Foundation Trust Partner Member
- One PMS Partner Member
- One Local Authority Partner Member
- One Healthwatch representative from Bedford Borough, Central Bedfordshire, Luton and Milton Keynes

4.2 The non-voting membership of the Committee shall be:

- ~~A nominated local Healthwatch representative.~~
- A nominated Voluntary Community Social Enterprise representative.
- A clinician or care professional linked to the NHS Bedfordshire, Luton and Milton Keynes ~~Integrated Care Board~~ICB Health and Care Senate.
- ICB Chief of Transformation

4.3 The Committee may also ~~have regular~~ ~~invite~~ ~~participants~~invite participants who are not drawn from the ~~Integrated Care Board~~ICB. Participants will receive advanced copies of the notice, agenda, and papers for meetings. They may be invited to attend any or all the meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote.

- ~~Communication and Engagement Leads in partner organisations~~
- ~~Local Authorities engagement / social justice~~
- ~~Public Health~~
- ~~Carers organisation~~
- ~~Faith communities~~
- ~~Age UK~~
- ~~Maternity Voice Partnership~~
- ~~Young person representative~~
- ~~Clinicians~~
- ~~Participants from communities to share lived experiences~~
- ~~Patient experience representatives~~
- ~~Subject area specialists dependent on agenda~~

4.4 The Committee may from time to time vary both its voting and non-voting membership for fixed periods of no more than six months to address emerging priorities. Variation of voting membership must be approved by the ~~Integrated Care Board~~ICB.

5.0 Meetings

5.1 The Committee shall meet a minimum of 4 times a year (more frequent meetings may be necessary subject to work plan). Sessions may also be held for development and work plan setting.

5.2 Meetings will take place in public where possible (though virtual meetings remain an option if necessary). ~~Meetings can provide an opportunity to outreach into local communities, where Bedfordshire, Luton and Milton Keynes Health and Care Partnership partners would come together to listen to local people, answer questions and hear any concerns that are facing residents.~~

5.3 Held in communities across Bedfordshire, Luton and Milton Keynes, meetings will be held on different days and times to give more people the opportunity to participate.

6.0 Quorum

6.1 The Committee shall be quorate if it is attended by:

- At least one Non-Executive Member.
- The Chief of Assurance and Corporate Services or their nominated deputy.
- At least one of the non-voting members.

6.2 If the Committee is not quorate due to either attendance or the need to exclude one or more members from a meeting or part of a meeting to manage conflicts of interests then:

- The Chair may transact urgent business ("Chair's Action") and make a report on this to the ~~Integrated Care Board~~ICB to which the business relates.

- The Chair, with the agreement of the Director accountable for the activity or function to which the business relates, may delegate the matter to an existing Committee or working group.
- The Chair may convene an additional meeting alongside scheduled meetings to ensure Committee business is transacted.

6.3 The Committee is expected to reach decisions by consensus. Where a consensus cannot be reached a vote shall be held.

6.4 Each member shall have one vote and if votes are tied the Chair shall cast a second, deciding vote.

7.0 Authority and Accountability of the Committee

7.1 The Committee is authorised to act on their behalf by the ~~Integrated Care Board~~ICB.

7.2 It is accountable to the ~~Integrated Care Board~~ICB or anybody or person to which the ~~Integrated Care Board~~ICB have delegated this function.

7.3 It may not act outside the ~~Integrated Care Board~~ICB's Constitution or the Scheme of Reservation and Delegation of the ~~Integrated Care Board~~ICB.

8.0 Committee Management

8.1 Meeting Agendas shall be approved by the Committee Chair.

8.2 Meetings shall consider matters relating to functions set out in these terms of reference only.

8.3 All members of the Committee and all attendees at its meeting shall be accountable for declaring any conflicts of interests that may arise from Committee business or meetings.

8.4 In the event of a conflict of interest arising then the Chair shall decide how this should be managed, including one or more of:

- Ensuring a record of the conflict of interest is made in the minutes of the meeting.
- Excluding the person with the conflict from the meeting.
- Excluding the person with the conflict from the item or business to which the conflict relates.
- Seeking advice from the governance lead at the ~~Integrated Care Board~~ICB.

8.5 In the event of a conflict of interest arising for the Chair, then another Non-Executive Member shall be asked to act as Chair for the meeting or business to which the conflict relates.

9.0 Secretariat and Administration

9.1 The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed at least five working days before each meeting in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action

points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues / areas of interest / policy developments.
- Action points are taken forward between meetings and progress against those actions is proactively monitored.

10.0 Review

10.1 The Committee will review its effectiveness at least annually.

10.2 These Terms of Reference will be reviewed at least every two years and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

Item 5.2

Governance Handbook Appendix F – Primary Care Commissioning and Assurance Committee Terms of Reference v2.0 approved by the Board of the Integrated Care Board 29-07-2022 with proposed amendments v3.0 presented to PCC&AC 09.09.22.

1.0 Constitution

1.1 The Primary Care Commissioning and Assurance Committee (the Committee) is established by the Integrated Care Board (ICB) as a Committee of the Board of the ICB (the Board) in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is a non-executive chaired Committee of the Board, and its members are bound by the Standing Orders and other policies of the ICB.

2.0 Authority

2.1 The Primary Care Commissioning and Assurance Committee is accountable to the ICB and shall report to the Board on how it discharges its delegated primary care commissioning functions for primary medical services from July 2022 and pharmacy, optometry and dental services from April 2023.

2.2 The ICB holds only those powers as delegated in these Terms of Reference as determined by the NHS England Commissioning Board.

3.0 Purpose

3.1 The Committee exists to scrutinise and provide assurance to the ICB that there is an effective system of primary medical services commissioning that supports it to effectively deliver its statutory and strategic objectives and provide sustainable, high quality primary care.

3.1.1 The Committee acknowledges in exercising the ICB's functions (including those delegated to it), it must comply with the statutory duties including:

a) Management of conflicts of interest (section 14O);
b) Duty to promote the NHS Constitution (section 14P);
c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
d) Duty as to improvement in quality of services (section 14R);
e) Duty in relation to quality of primary medical services (section 14S);
f) Duties as to reducing inequalities (section 14T);
g) Duty to promote the involvement of each patient (section 14U);
h) Duty as to patient choice (section 14V);
i) Duty as to promoting integration (section 14Z1);
j) Public involvement and consultation (section 14Z2).

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k) Delivery of the ICB & Health & Care Partnership strategic objectives for primary care commissioning.

3.1.2 The Committee acknowledges that it is subject to any directions made by NHS England or the Secretary of State to the ICB.

3.2 Role of the Committee

3.2.1 The Committee has been established in accordance with the above statutory provisions to enable the members to, for example, make collective decisions on the review, planning and procurement of primary medical services in Bedfordshire, Luton and Milton Keynes under delegated authority from NHS England.

3.2.2 The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the current NHS Act.

3.2.3 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and Bedfordshire, Luton and Milton Keynes ICB which will sit alongside the delegation and Terms of Reference.

3.2.4 The functions of the Committee are undertaken in the context of a desire to promote increased quality, efficiency, productivity and value for money and to remove administrative barriers.

4.0 Membership and attendance

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint no fewer than eight members of the Committee including one who is a Non-Executive Members of the Board (from the ICB). Other attendees of the Committee need not be members of the Board, but they may be.

4.3 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

4.4 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.

Chair and Deputy Chair

4.5 The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

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4.6 If the Chair has a conflict of interest, then the co-chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

4.7 Members with Voting rights:

a) Non-Executive Member (Chair)
b) ICB Chief Executive Officer
c) ICB Chief Primary Care Officer
d) ICB Chief Finance Officer
e) ICB Chief Nursing Director
f) ICB Chief Medical Director
g) At least two Clinical Representatives who have primary care leadership experience delivering either primary medical, primary dental and primary ophthalmic services or services that may be provided as pharmaceutical services, following appointment of the ICB Partner Members or clinical lead roles. One of these members will be the Deputy Chair of the Committee.

4.8 Other attendees – Non-voting

4.8.1 The following non-voting attendees will be invited to attend the meetings of the Primary Care Commissioning and Assurance Committee, as subject area specialists and as pertinent to Agenda items:

a) Associate Directors of Primary Care and Transformation (2)
b) Associate Director of Primary Care Development
c) Head of Primary Care Contracting
d) Associate Director of Medicines Optimisation
e) NHS England GP Contract Manager or Deputy' (co-opted as member of Primary Care ~~Commissioning~~ Delivery Group)
f) One representative from each Health Watch (4)
g) One representative from each Local Medical Committee (2)
h) Health and Wellbeing Board Representatives
i) One or more Public Health Representatives.

5.0 Meeting Quoracy and Decisions

5.1 The Primary Care Commissioning and Assurance Committee shall meet in private and public on a quarterly (four times per year) basis (to be determined by the ICB). Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

5.1.1 Meetings of the Committee shall be held in public, subject to the application of a)

a) The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings)

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whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for the other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

Quorum

5.2 There will be a minimum of one Non-Executive Member - Chair or nominated deputy for the meeting, ICB Chief Primary Care Officer or ICB Chief Medical Director, ICB Chief Finance Officer plus one other ICB Executive Board Member.

5.3 Where members are required for quoracy but unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate and vote on their behalf. No other deputies are permissible.

Decision making and voting

5.4 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.5 Only voting members of the Committee, or deputies for members required for quoracy, may vote. Each voting member is allowed one vote and a majority will be conclusive on any matter.

5.6 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

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6.0 Responsibilities of the Committee

6.1 The responsibilities of the Primary Care Commissioning and Assurance Committee will be authorised by the ICB Board. It is expected that the Committee will:

a) ~~Oversee~~ Oversight and assurance of the decisions made by the Primary Care Delivery Group to include: ~~commissioning of:~~

i. GMS and APMS contracts (including the design of APMS contracts, ~~monitoring~~ performance of contracts, ~~taking~~ appropriate contractual action such as issuing branch/remedial notices, and removing a contract) has been applied;

ii. ~~Newly~~ the commissioning of newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");

iii. Decision making on whether to establish new GP practices in an area;

iv. Approving practice mergers;

v. Making decisions on discretionary payment;

vi. Making decisions relating to Primary Care Estates issues;

vii. Making decisions relating to Primary Care Digital issues;

~~v.~~viii. Making decisions relating to Primary Care Workforce.

b) Utilise local clinical knowledge to influence the development of and investment in general practice to improve access to services and taking a population health management approach;

c) Develop and commission end to end care and increased autonomy to shape future primary care services;

d) Take an active role in driving forward the NHS Long Term Plan;

e) Provide assurance on and to manage the budget for commissioning of primary medical services and future pharmacy, optometry and dental services (from 2024) in Bedfordshire, Luton and Milton Keynes;

f) Plan, ~~including population health assessment,~~ primary medical care services in the BLMK area in response to population health assessment;

g) Undertake reviews of primary medical services in the BLMK area;

h) Co-ordinate a common approach to the commissioning of primary care services generally;

i) Ensure collaborative working on monitoring and addressing issues of quality in primary care based on the principle of continuous improvement;

j) Agree and put forward the key primary care priorities that are included within the ICB strategy/annual plan, including priorities to address variation/inequalities in care;

k) Oversee and monitor delivery of primary care related ~~the~~ ICB key statutory requirements;

l) Review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to primary care, and high-risk operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner;

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m) Oversee and scrutinise the ICB's response to all relevant (as applicable to primary care) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the Department of Health and Social Care, NHS England and other regulatory bodies / external agencies (e.g. Care Quality Commission, National Institute of Clinical Excellence) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained;
n) Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites;
o) Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place;
p) Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services;
q) Oversee the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety;
r) Have oversight of and approve the Terms of Reference and work programmes for the group reporting into the Primary Care Commissioning and Assurance Committee (Primary Care ~~Commissioning~~ Delivery Group).
s) The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.
t) Provide assurance on delivery of the Primary Care Strategy including Phase one - Primary Medical Services Transformation.

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7.0 Behaviours and Conduct

ICB Values

7.1 Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and Diversity

7.2 Members must consider the equality and diversity implications of decisions they make.

Declarations of Interest

7.3 All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes.

Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

8.0 Accountability and reporting

8.1 The Primary Care Commissioning and Assurance Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.

8.2 The Committee will advise the Audit and Risk Assurance Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.

8.3 The Committee will receive scheduled assurance report from its delegated group the Executive led Primary Care Delivery Group which will include quarterly assurance reports from the Primary Care Workforce & Education Network Training Hub Steering Group and the Estates Working Group. Any delegated groups would need to be agreed by the ICB Board.

9.0 Secretariat and Administration

9.1 The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

10.0 Review

10.1 The Committee will review its effectiveness at least annually.

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10.2 These Terms of Reference will be reviewed at least every two years and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

10.3 The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

11.0 Responsibilities of the Committee to provide assurance of Delegated Functions

11.1 The Primary Care Commissioning and Assurance Committee is responsible for providing the ICB with assurance in relation to its decisions for the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:

i) Decisions made in relation to Directed and Local Enhanced Services and Local Incentive Schemes (including the design of such schemes);

ii) decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;

iii) decisions made about 'discretionary' payments;

iv) decisions about commissioning urgent same day access ~~care. (including home visits as required) for out of area registered patients;~~

~~a) the approval of practice mergers;~~

~~b)~~a) Ensuring robust planning for primary medical care services in the ~~Area~~area, including carrying out needs assessments;

~~c)~~b) undertaking reviews of primary medical care services in the ~~Area~~area;

~~d)~~c) providing assurance on contractual compliance and decision making in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the Care Quality Commission where the Care Quality Commission has reported non-compliance with standards (but excluding any decisions in relation to the performers list);

~~e)~~d) providing assurance and oversight of the management of the Delegatedprimary medical services ~~Funds~~ funds in the ~~Area~~area;

~~f)~~e)Ensuring compliance with the Premises Costs Directions (PCD) functions;

~~g)~~f) co-~~ordinating~~ ordination of a common approach to the commissioning of primary care services with other commissioners in the ~~Area~~ area where appropriate; and

~~h)~~g) such other ancillary activities as are necessary to exercise the Delegated Functions.

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NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
17. Annual Cycle of Business

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"	
Please state which strategic priority and / or enabler this report relates to	
Strategic priorities	
☐	**Start Well:** Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
☐	**Live Well:** People are supported to engage with and manage their health and wellbeing.
☐	**Age Well:** People age well, with proactive interventions to stay healthy, independent and active as long as possible.
☐	**Growth:** We work together to help build the economy and support sustainable growth.
☐	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

Enablers			
Data and Digital ☐	Workforce ☐	Ways of working ☐	Estates ☐
Communications ☐	Finance ☐	Operational and Clinical Excellence ☐	Governance and Compliance ☒
Other ☐ (please advise):			

What are the members being asked to do?		
Approve ☐	Note ☐	Discuss ☒

Report Author	Secretariat
Date to which the information this report is based on was accurate	21-09-2022
Senior Responsible Owner	Chair of the Committee

Executive summary
The purpose of this paper is to present the Annual Cycle of Business and discuss which items should be on the Agenda for the next meeting on 25th November 2022.
What are the available options?
To discuss and agree agenda items.
Recommendation/s
The members are asked to **discuss** the Annual Cycle of Business.
Key Risks and Issues
There are none identified.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒

There are none identified.
Are there any financial implications or other resourcing implications?
There are none identified.
How will / does this work help to address the Green Plan Commitments? Click to view Green Plan
This is not applicable in this circumstance.
How will / does this work help to address inequalities?
This is not applicable in this circumstance.
The following individuals were consulted and involved in the development of this report:
The Committee Chair.
Next steps:
The Secretariat will draft the Agenda for the next meeting and arrange an Agenda setting meeting with the Committee Chair and the Executive Lead nearer the time of the next meeting to finalise the Agenda.
Appendices
Appendix A – Draft Annual Cycle of Business

Appendix A

	Accountable Person (name on agenda)	Author/s	25/11/2022	27/01/2022	24/02/2023 EGM	31/03/2022
Opening Actions						
Welcome, Introductions and Apologies	Chair	Governance	✓	✓		✓
Relevant Persons Disclosure of Interests - Register of Interests	Chair	Governance	✓	✓		✓
Approval of Minutes and Matters Arising	Chair	Governance	✓	✓		✓
Review of Action Tracker	Chair	Governance	✓	✓		✓
Chair's Report (Verbal)	Chair	-	✓	✓		✓
Chief Executive's Report	Chief Executive	Comms to support	✓	✓		✓
Resident's Story	tbc	tbc	Moved to later in agenda - and sometimes part of another session			
Strategy						
100 Day Plan	Chief Executive					
Integrated Care Strategy	Interim CTO	Hilary Tovey				
Fuller Stocktake - after 29/7 quarterly update on implementation	Chief Primary Care Officer	CPCO	✓			
Milton Keynes (MK) Together Health & Care Partnership " MK Deal"	Michael Bracey	David Stout				
Percutaneous Coronary Intervention Provision	Chief Medical Officer	Michael Ramsden				
Approach to Srategic Risk Management	Chief of System Assurance & Corporate Services	COSACS				
Working with People & Communities Strategy	Chief of System Assurance & Corporate Services	Michelle Summers	✓			
Digital Strategy						
Head and Neck Cancer Services	Chief Medical Officer	Kathy Nelson	✓ deferred from sept			
Strategy T&F Group - report back	Interim CTO	Richard Alsop				
Estates utilisation update	Chief Finance Officer	Nikki Barnes				
People Board/Plan Update	Chief People Officer	John Sysons				

	Accountable Person (name on agenda)	Author/s	25/11/2022	27/01/2022	24/02/2023 EGM	31/03/2022
Operational						
Quality & Performance Statement	Chief Nursing Director	Perf Team/Anne Murray				
Finance Report - Opening ICB Budget	Chief Finance Officer	Stephen Makin				
Winter Plan	??					
LMNS Equity & Equality Plan - submission due by 30/9						
Children & Young People Deep Dive from SOAG	Chair	??				
Workforce Race Equality Standard (WRES)	Chief People Officer	?				
Resident's Story	COSACS ?	?	✓	✓		✓
Governance						
Confirmation of Board Appointments	Chair	Governance				
Integrated Care Board Constitution	Chief of System Assurance &	Governance				
Integrated Care Board Governance Handbook	Chief of System Assurance &	Governance				
Integrated Care Board Policies : Conflic of Interest Management & Standards of Business Conduct, Working with People & Communities, Risk Management Framework, adop EBI clinical policies	Chief of System Assurance & Corporate Services	Governance				
CCG ARA for 2021/22 for approval	Chief Executive & Chief Finance Officer	Dean Westcott				
Committee Membership: approve appts to cttees, approve change to membership of Remcom	Chief of System Assurance & Corporate Services	Sarah Feal				
Business Continuity Policy	Chief of System Assurance & Corporate Services	Ola Hill				
East Kent Maternity Report	Chief of System Assurance & Corporate Services		✓			
Accept new delegated authority for Primary Medical Servies					✓	
Draft VCSE MOU			✓			
Committee reports	Committee Chairs	Governance	✓	✓	✓	✓
Annual Cycle of Business	Chair	Governance				
Communications from the meeting to all ICS partner organsations	Chief of System Assurance & Corporate Services	-	✓	✓		✓
Questions from the Public	Chair					
Review of Meeting Effectiveness	Chair and all Board Members	-	✓	✓		✓

	Accountable Person (name on agenda)	Author/s	25/11/2022	27/01/2022	24/02/2023 EGM	31/03/2022
Closing Actions						
Any Other Business	Chair	-	✓	✓		✓
Date and Time of Next Meeting	Chair	-	✓	✓		✓
To clarify which section						
BCA Progress/Forward look	David Carter	Alison Blair	✓			
Voluntary Community and Social Enterprise MOU	Exec tbc	Sonal Mehta	✓			
An Undetermined Date						
Review Constitution by March 23						
Review Governance Handbook regularly						