NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Meeting of the Board of the ICB in PUBLIC

27 September 2024 - 09.00 – 11.45

Council Chamber, Milton Keynes County Council, 1 Saxon Gate East,

Milton Keynes MK9 3EJ

Item No.	Item	Purpose	Executive	Timing
Opening Items				
1.	Welcome and Introductions a) Apologies b) Quoracy c) Relevant Persons' Disclosure of Interests d) Minutes from meeting held on 19 July 2024 and Matters Arising e) Action Tracker f) Board Decision Planner	 Note Note Update Approve Approve Update	Chair	9.00
2.	Questions from the Public	-	Chair	
3.	Resident's Story	-	Chief Of Strategy and Assurance	
4.	Annual Report & Accounts 2023/24	Discuss	Chief Executive and Chief Finance Officer	
5.	Chair's report - verbal	Discuss	Chair	
6.	CEO report	Approve	Chief Executive	
System Strategy				
7.	Our Strategies in BLMK, and next steps for their development	Approve	Chief Executive and Chief of Strategy & Assurance	9.25
8.	Health Services Strategy	Approve	Chief Medical Director	
9.	BLMK Infrastructure Strategy	Approve	Chief Finance Officer	
10.	Utilisation of the NHS App in BLMK	Discuss	Chief Primary Care Officer/ Chief Medical Director/CEO MKUH	
11.	Stay Well Winter Plan	Discuss	Chief Operating Officer	
System Assurance				
12.	Audit & Risk Assurance Committee – • Chair's report	Assure	Chair, Audit & Risk Assurance Committee / Chief of Strategy & Assurance	11.00

	• System Risks and Board Assurance Framework • Risk Management Framework	Approve		
13.	Bedfordshire Care Alliance Committee Chair's Update from meeting on 19 September 2024- verbal	Assure	Chair, Bedfordshire Care Alliance Committee	
14.	Quality & Performance: • Quality & Performance Committee Chair's Update • Performance Report	Assure Assure	Chair, Quality & Performance Committee Chief Nurse / Chief of Strategy & Assurance/	
15.	Finance & Investment: • Finance & Investment Committee Chair's Update • ICS Finance Report Month 4 (July 24)	Assure Assure	Chair, Finance & Investment Committee Chief Finance Officer	
16.	Primary Care Commissioning & Assurance Committee Chair's update	Assure	Chair, Primary Care Commissioning & Assurance Committee	
17.	Specialist Commissioning Team Transfer from NHS England into BLMK	Assure	Chief People Officer	
18.	BLMK Health and Care Partnership 19 September – verbal	Assure	Chair of Health and Care Partnership	
ICB Organisational Decisions, Governance and Assurance				
19.	Corporate Governance Update	Approve and Note	Chief of Strategy & Assurance	11.30
Closing Items				
20.	Communication from the Meeting	Agree	Chair	11.40
21.	Meeting Evaluation	Discuss	Chair	
22.	Any Other Business		Chair	

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.

Next meeting
Date: Friday 13 December 2024
Time: 9am
Venue: Milton Keynes Council

Surname	Forename	Position within, or relationship with the Integrated Care Board	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Details of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Borrett	Alison	Non Executive Member	Yes	N	N	N	N	Director, 2Billys Ltd, Company no 14038119, Unit 8 Churchill Court, 58 Station Rd, North Harrow HA2 7SA	11/04/2022	Ongoing	No conflict, as our cookie business does not provide goods or services to BLMK ICB. If this was to change in the future I would update my DOI and declare any interest.	21/06/2022
Bracey	Michael	Chief Executive, Milton Keynes Council	Yes	Y				Employee of Milton Keynes City Council	2009	Ongoing	None required	21/11/2022
Carter	David	Chief Executive, Bedfordshire Hospitals Foundation Trust	Yes	Y				Chief Executive of Bedfordshire Hospitals NHS Foundation Trust	08/05/2017	Ongoing		18/05/2022
Carter	David	Chief Executive, Bedfordshire Hospitals Foundation Trust	Yes				Y	Wife employed by NHS England Eastern Region	2019	ongoing		18/05/2022
Cartwright	Sally	Director of Public Health, Luton Council	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	Declare in line with conflicts of interest policy	27/05/2022
Cox	Felicity	Chief Executive, Bedfordshire, Luton and Milton Keynes Integrated Care Board	Yes		Y			I am a registered pharmacist with the General Pharmaceutical Council (GPC) and a member of the Royal Pharmaceutical Society	17/08/1987	Ongoing	I will excuse myself should an interest arise	14/06/2022
Cox	Felicity	Chief Executive, Bedfordshire, Luton and Milton Keynes Integrated Care Board	Yes		Y			I am a trustee of a charity as a member (and secetary) of the parochial church council of the Ecclesiastical Parish of Bushey	01/07/2023	Ongoing	We supply no services to the ICB	13/10/2023
Gill	Manjeet	Non Executive Member	Yes	Y				Non Executive Director, Sherwood Forest NHS Hospitals Foundation Trust	11/11/2019	Ongoing	Would flag any conflict in agendas	27/09/2022
Gill	Manjeet	Non Executive Member	Yes	Y				Managing Director, Chameleon Commercial Services Ltd, 12 St Johns Rd, LE2 2BL	09/09/2017	Ongoing	Regular 1-1s flag any issue and agenda items	27/09/2022
Graves	Stuart Ross	Partner Member, Board of the BLMK ICB	Yes		Y			Chief Strategy & Digital Officer CNWL NHS Foundation Trust, 350 Euston Road, London NW1 3AX	May-20	Ongoing	Declare in line with conflicts of interest policy	15/11/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				Chief Executive Officer, NHS Milton Keynes University Hospital	2013	Ongoing	Declare in line with conflicts of interest policy	21/11/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Chair NHS Employers Policy Board	2021	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Trustee of NHS Conferation	2021	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Council Member - National Association of Primary Care	2020	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				Keele University - Lecturer	2016	Ongoing	Declare in line with conflicts of interest policy	16/05/2022

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Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				Advisor to Alphasights, MM3 Global Research, Silverlight and Stepcare	2018	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Chair, Clinical Research Network Thames Valley & South Midlands Partnership Group Meeting		Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Member, Oxford Academic Health Science Network		Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes				Y	Spouse: NED at DHSC	Nov-22	Ongoing	Declare in line with conflicts of interest policy	24//10/2023
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes				Y	Sister, Ruth Harrison, Director of Durrow Ltd	Circa 2012	Ongoing	Declare in line with conflicts of interest policy	21/11/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				National Director for Digital Channels	2023	Ongoing	Declare in line with conflicts of interest policy	01/02/2023
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes				Y	Spouse: Advisory work for: Cera Care, NAPC, G Square Private Equity Group, System C Health Information Technology Systems and Services, HUMA, Bain & Company, HSBUK, Carnell Farrar, PA Consulting, Global Counsel, Newmarket Strategy	2023	Ongoing	Declare in line with conflicts of interest policy	24/10/2023
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes				Y	Spouse: NED at Keys Group	2023	Ongoing	Declare in line with conflicts of interest policy	23/10/2023
Harrison	Mike	Co-Chief Executive Officer of Beds and Herts Local Medical Committee	Yes		Y			Beds & Herts LMC Ltd, Astonbury Farm, Astonbury Lane, Aston, Stevenage SG2 7EG	03/07/2017	Ongoing	Declare in line with conflicts of interest policy	06/12/2022
Head	Vicky	Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes.	No									27/06/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes	Y				The Bridge Primary Care Network Clinical Director	01/04/2021	Ongoing	May need to be excluded from decisions regarding Primary care Networks	11/05/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Member, NHS Confederation Primary Care Network	07/07/2019	Ongoing	Declare conflict during discussions	08/09/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Member, National Association of Primary Care (NAPC) Council	01/10/2020	Ongoing	Declare conflict during discussions	08/09/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Trustee, Arts for Health Milton Keynes	01/04/2020	Ongoing	Declare conflict during discussions	08/12/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Chair, Milton Keynes Christian Centre (*was previously Trustee)*	01/09/2023	Ongoing	Declare conflict during discussions	08/12/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes	Y				GP partner, Newport Pagnell Medical Centre	01/02/2004	Ongoing	May need to be excluded from decisions regarding Primary Care Networks	08/12/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes	Y				Director, Primary Care Alliance MK	01/05/2024	Ongoing	Declare conflict during discussions	26/06/2024
Kufeji	Omotayo	Primary Services Partner Member	Yes	Y				Trustee, Milton Keynes Urgent Care Centre	01/08/2023	Ongoing	Declare conflict during discussions	26/09/2023
Makarem	Rima	Chair, Bedfordshire, Luton and Milton Keynes Integrated Care Board	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, Bedfordshire, Luton and Milton Keynes Integrated Care Board	Yes	Y				Chair of Queen Square Enterprises Ltd (remunerated)	01/11/2020	Ongoing	Declare in line with conflicts of interest policy	17/06/2022
Makarem	Rima	Chair, Bedfordshire, Luton and Milton Keynes Integrated Care Board	Yes	Y				Lay Member of General Pharmaceutical Council	Apr-19	Ongoing	Declare in line with conflicts of interest policy	17/06/2022

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Makarem	Rima	Chair, Bedfordshire, Luton and Milton Keynes Integrated Care Board	Yes		Y			Trustee of LifeArc	June 2023	Ongoing	Declare in line with conflicts of interest policy	26/04/2023
Manchanda	Vineeta	Non Executive Member, Integrated Care Board, Chair of Audit Committee	Yes	Y				IBMDS - Director - Consultancy Company - husband's consultancy company. The company provides consultancy on contracts/negotiation/culture etc.	Dec-11	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/07/2023
Manchanda	Vineeta	Non Executive Member, Integrated Care Board, Chair of Audit Committee	Yes			Y		Worcester College, Oxford University	Sep-22	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/07/2023
Manchanda	Vineeta	Non Executive Member, Integrated Care Board, Chair of Audit Committee	Yes	Y				RegTech Open Project PLC NED & Audit Chair, a small newly listed fintech company that provides a proprietary operational resilience platform.	Aug 23	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	23/10/2023
Manchanda	Vineeta	Non Executive Member, Integrated Care Board, Chair of Audit Committee	Yes	Y				NED, NW London Acute Provider Collaborative	01/05/2024		Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	18/01/2024
Mattis	Lorraine	Associate Non Executive Member	Yes	Y				CEO, University of Suffolk Dental CIC	Jun-23	Ongoing	Declared in line with conflicts of interest policy	08/08/2023
Pointer	Shirley	Non-Executive Member, Chair Remuneration Committee	Yes		Y			Bpha (a not for profit Housing Association). Non-Executive Director and Chair of the Remuneration Committee	Apr-19	Ongoing	Declare in line with conflicts of interest policy	15/12/2022
Pointer	Shirley	Non-Executive Member, Chair Remuneration Committee	Yes			Y		Pavilions Management Co Ltd, (residents management co), Director. This is a voluntary role which is not remunerated	Sep-20	Ongoing	Declare in line with conflicts of interest policy	15/12/2022
Porter	Robin	Chief Executive, Luton Borough Council	Yes	Y				Chief Executive of Luton Council, an ICB Partner organisation	May-19	Ongoing	Declare in line with conflicts of interest policy	16/11/2022
Poulain	Nicky	Chief Primary Care Officer	Yes		Y			Registered nurse and midwife and a member of the RCN			Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	17/02/2023
Reckless	Ian	Chief Medical Officer, BLMK ICB (part time secondment)	Yes	Y				Chief Medical Officer and Deputy Chief Executive, Milton Keynes University Hospital NHS FT	April 2016	Secondment in to 11/11/24	Declare in line with conflicts of interest policy	16/05/2024
Reckless	Ian	Chief Medical Officer, BLMK ICB (part time secondment)	Yes		Y			Non Executive Director, Royal Orthopaedic Hospital Birmingham	November 2022	Secondment in to 11/11/24	Declare in line with conflicts of interest policy	16/05/2024

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Reckless	Ian	Chief Medical Officer, BLMK ICB (part time secondment)	Yes		Y			Director / Chair, ADMK Ltd (wholly owned subsidiary of MKUH NHS FT)	December 2017	Secondment in to 11/11/24	Exclusion from involvement in related meeting or decision-making (if subsidiary was to take on any ICB business).	16/05/2024
Reckless	Ian	Chief Medical Officer, BLMK ICB (part time secondment)	Yes			Y		Director, JTER Trading (antiquities and property)	November 20921	Secondment in to 11/11/24	No conflict is envisaged.	16/05/2024
Roberts	Martha	Chief People Officer, BLMK Integrated Care Board	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	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2011
Shah	Mahesh	Partner Member	Yes				Y	RightPharm Ltd, 60a Station Road, North Harrow, HA2 7SL, co no 08552235, community pharmacy, son & sisters	28/03/2014	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes				Y	Calverton Pharmacy Ltd, Ashleigh Mann 60a, Station Road, North Harrow HA2 7SL, co no 07203442, community pharmacy, son & sisters	03/04/2018	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	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	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes		Y			Committee Member, Bedfordshire Local Pharmaceutical Committee	1984	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes		Y			Community Pharmacy PCN Lead, Oasis Primary Care Network, Luton	06/02/2020	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Stanley	Sarah	Chief Nurse	No									08/09/2022
Sunduza	Lorraine	Interim CEO, East London Foundation Trust	Yes	Y				Interim Chief Executive, East London NHS Foundation Trust	21/08/2023	Ongoing	Declare in line with conflicts of interest policy	26/09/2023

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Sunduza	Lorraine	Interim CEO, East London Foundation Trust	Yes		Y			Member of Central Bedfordshire Health and Wellbeing Committee	21/08/2023	Ongoing	Declare in line with conflicts of interest policy	26/09/2023
Sunduza	Lorraine	Interim CEO, East London Foundation Trust	Yes		Y			Member of BLMK Bedford Care Alliance Committee	21/08/2023	Ongoing	Declare in line with conflicts of interest policy	26/09/2023
Sunduza	Lorraine	Interim CEO, East London Foundation Trust	Yes		Y			Member of North East London Population Health and Integrated Care Committee	21/08/2023	Ongoing	Declare in line with conflicts of interest policy	26/09/2023
Sunduza	Lorraine	Interim CEO, East London Foundation Trust	Yes		Y			Member of North East London NED Remuneration Committee	21/08/2023	Ongoing	Declare in line with conflicts of interest policy	26/09/2023
Sunduza	Lorraine	Interim CEO, East London Foundation Trust	Yes		Y			Member of North East London Mental Health, Learning Disability & Autism Committee	21/08/2023	Ongoing	Declare in line with conflicts of interest policy	26/09/2023
Sunduza	Lorraine	Interim CEO, East London Foundation Trust	Yes		Y			Member of City & Hackney Integrated Commissioning Board	21/08/2023	Ongoing	Declare in line with conflicts of interest policy	26/09/2023
Sunduza	Lorraine	Interim CEO, East London Foundation Trust	Yes		Y			Member of City & Hackney Health & Wellbeing Board	21/08/2023	Ongoing	Declare in line with conflicts of interest policy	26/09/2023
Sunduza	Lorraine	Interim CEO, East London Foundation Trust	Yes		Y			Member of Newham Health & Wellbeing Board	21/08/2023	Ongoing	Declare in line with conflicts of interest policy	26/09/2023
Sunduza	Lorraine	Interim CEO, East London Foundation Trust	Yes		Y			Member of East of England Provider Collaborative Board	21/08/2023	Ongoing	Declare in line with conflicts of interest policy	26/09/2023
Sunduza	Lorraine	Interim CEO, East London Foundation Trust	Yes		Y			Member of North East London Community Health Collaborative Committee	21/08/2023	Ongoing	Declare in line with conflicts of interest policy	26/09/2023
Sunduza	Lorraine	Interim CEO, East London Foundation Trust	Yes		Y			Member of NHS England London People Board including the EDI Committee	21/08/2023	Ongoing	Declare in line with conflicts of interest policy	26/09/2023

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Sunduza	Lorraine	Interim CEO, East London Foundation Trust	Yes		Y			Member, Unison	21/08/2023	Ongoing	Declare in line with conflicts of interest policy	26/09/2023
Sunduza	Lorraine	Interim CEO, East London Foundation Trust	Yes		Y			Named shareholder for Health E1	21/08/2023	Ongoing	Declare in line with conflicts of interest policy	26/09/2023
Sunduza	Lorraine	Interim CEO, East London Foundation Trust	Yes		Y			Named shareholder for City & Hackney GP Federation	21/08/2023	Ongoing	Declare in line with conflicts of interest policy	26/09/2023
Sunduza	Lorraine	Interim CEO, East London Foundation Trust	Yes		Y			Named shareholder for Newham GP Federation	21/08/2023	Ongoing	Declare in line with conflicts of interest policy	26/09/2023
Swain	Sahadev	Partner Member	Yes	Y				General Practitioner, Biscot Group Practice, Luton,LU3 1HA	Mar-06	Ongoing	Exclusion from involvement in related meeting or decision-making	06/07/2023
Swain	Sahadev	Partner Member	Yes		Y			Representative and Board Member, Beds and Herts Local Medical Council	2018	Ongoing	Exclusion from involvement in related meeting or decision-making	06/07/2023
Swain	Sahadev	Partner Member	Yes		Y			Board Member, Beds and HertsFaculty ,Royal College of General Practitioners	2012	Ongoing	Exclusion from involvement in related meeting or decision-making	06/07/2023
Swain	Sahadev	Partner Member	Yes		Y			Member, Audit and Risk Committee, Royal College of General Practitioners	2019	Ongoing	Exclusion from involvement in related meeting or decision-making	06/07/2023
Swain	Sahadev	Partner Member	Yes			Y		Chairman, Shree Jagannath Society ,UK	2020	Ongoing	Exclusion from involvement in related meeting or decision-making	06/07/2023
Swain	Sahadev	Partner Member	Yes		Y			Lead Trainer, Equalty, Primary Care Network Training HUB, Luton	2023	Ongoing	Exclusion from involvement in related meeting or decision-making	06/07/2023
Taffetani	Maxine	Healthwatch Representative for Bedfordshire, Luton and Milton Keynes	Yes	Y				Employee of Healthwatch Milton Keynes	2017	Ongoing	Declare in line with conflicts of interest policy	14/12/2022
Westcott	Dean	Chief Finance Officer	Yes				Y	Wife is Senior Mental Health Transformation Manager at West Essex CCB	01/06/2021	Ongoing	Declare in line with conflicts of interest policy	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes			Y		Civil partner, Advanced Nurse Practitioner (Walnut Tree Health Centre, Milton Keynes)	2013	30/04/2024	No involvement in relation to decision making	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes		Y			Stonedean, Practice - Sessional GP/former partner	01/06/2007	30/04/2024	No involvement in relation to decision making	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes		Y			General Medical Council Associate	2012	30/04/2024	Exclusion of self from involvement in related meetings, projects or decision-making	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes	Y				Akeso (coaching network) – coach – Executive and Performance Coach	01/04/2021	30/04/2024	Open declaration, no monies received	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes	Y				NHS England – Appraiser	2010	30/04/2024	Exclusion of self from involvement in related meetings, projects or decision-making relating to any relevant practitioners	14/06/2022

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Whiteman	Sarah	Chief Medical Director	Yes	Y				NED role at James Paget Hospital	01/10/2023	30/04/2024	No involvement in relation to decision making	18/10/2023
Whiteman	Sarah	Chief Medical Director	Yes	Y				NED, Lincolnshire Partnership Trust	01/02/2024	30/04/2024	Mostly hybrid working – ICB work takes priority until retirement 30.4.24	01/02/2024
Winn	Matthew	Chief Executive Officer, Cambridgeshire Community Services	Yes	Y				Accountable Officer of Cambridgeshire Community services NHS Trust, which receives funding from the ICB, and all four Councils in the BLMK area (Luton, Bedford Borough, Central Bedfordshire and Milton Keynes) to provide services to local residents	2010	Ongoing	Declare in line with conflicts of interest policy. Exclusion from involvement in related meeting or decision-making	09/08/2022
Wogan	Maria	Chief of Strategy & Assurance	Yes	Y				I am a Director of Netherby Network Limited which is a consultancy company that has provided services to Milton Keynes Clinical Commissioning Group in the past. It does not currently provide any services for health or care clients. Address: 69 Midland Road, Olney, MK46 4BP	Mar-14	13/03/2024	No actions required as the company has been dissolved.	13/03/2024
Wogan	Maria	Chief of Strategy & Assurance	Yes			Y		I am a member of Inspiring Futures Through Learning Multi-Academy Trust which covers schools in Milton Keynes (MK) and Northamptonshire. Address: Fairfields Primary School, Apollo Avenues, Fairfields, Milton Keynes MK11 4BA	2016	Ongoing	Will be declared in any relevant meetings.	13/03/2024

Date: 19 July 2024
Time: 09.00 – 13.00
Venue: Central Bedfordshire Council, Priory House, Monks Walk, Chicksands, Shefford SG17 5TQ

Minutes of the Board of the Integrated Care Board (ICB)
In PUBLIC

Members:		
Dr Rima Makarem (Chair)	Chair	RM
Alison Borrett	Non-Executive Member (NEM) (*remotely)*	ABo
David Carter	Partner Member, NHS Trusts and Foundation Trusts	DC
Laura Church	Partner Member, Local Authorities	LC
Marcel Coiffait	Partner Member, Local	MC
Felicity Cox	Chief Executive Officer (CEO)	FC
Manjeet Gill	Non-Executive Member	MG
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
Vineeta Manchanda	Non-Executive Member	VM
Lorraine Mattis	Associate Non-Executive Member	LM
Shirley Pointer	Non-Executive Member	SP
Dr Ian Reckless	Chief Medical Director	IR
Mahesh Shah	Partner Member, Primary Medical Services	MSh
Sarah Stanley	Chief Nurse (CN)	SSt
Dean Westcott	Chief Finance Officer (CFO)	DW
Participants:		
Sally Cartwright	Director of Public Health, Luton	SCa
Vicky Head	Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes Councils *(from partway through item 8)*	VH
Kathryn Moody	Deputy Chief Operating Officer (*deputising for Anne Brierley)*	KM
Nicky Poulain	Chief Primary Care Officer	NP
Martha Roberts	Chief People Officer	MRO
Maxine Taffetani	Participant Member for Healthwatch within Bedfordshire, Luton and Milton Keynes	MTa
Cllr Martin Towler	Co-Chair, BLMK Health & Care Partnership	MTo
Maria Wogan	Chief of Strategy & Assurance	MWo
In attendance:		
Kim Atkin	Corporate Governance Officer *(minutes)*	KA
Sarah Breton	Associate Director Children & Maternity Commissioning	SB
Sanhita Chakrabarti	Deputy Chief Medical Director	SCh
Michelle Evans-Riches	Head of Governance	MER
Faith Haslam	Luton Place Lead *(from item 3)*	FH
Catherine Jackson	BLMK ICB Workforce Development Academy, People Directorate (items 1-3)	CJ
Michael Ramsden	Associate Director for Delivery (*from item 6 to 8)*	MRa
Michelle Summers	Associate Director, Communications & Engagement	MSu
Lorraine Sunduza *(invited attendee)*	Chief Executive Officer, East London Foundation Trust (ELFT)	LS
Matthew Winn *(invited attendee)*	CEO, Cambridgeshire Community Services (CCS)	MWi

Dominic Woodward-Lebihan	Deputy Chief of Strategy & Assurance	DWL
Alex Wrack	Bedford Borough Place Lead (*items 1-17)*	AW

There were 4 members of the public in attendance (remotely).

Apologies:		
Michael Bracey (*member)*	Partner Member, Local Authorities	MB
Anne Brierley *(participant)*	Chief Transformation Officer	ABr
Cllr Khtija Malik *(participant)*	Co-Chair, Health & Care Partnership	KM
Robin Porter *(member)*	Partner Member, Local Authorities	RP
Dr Sahadev Swain *(member)*	Partner Member, Primary Medical Services	SSw

No.	Agenda Item	Action
	Meeting Opening	
1.	The Chair **welcomed** all present to this meeting of the Board of the Bedfordshire Luton and Milton Keynes (BLMK) Integrated Care Board (ICB) in Public. The Chair advised that the meeting was being recorded for the purpose of the minutes only. a) Apologies were **noted** as above. The Chair welcomed Kathryn Moody who is deputising for Anne Brierley, Chief Operating Officer and Sarah Breton. b) It was confirmed that the meeting was **quorate**. When the meeting papers were circulated, members of the committee were asked to confirm that the Register of Interests was up to date in respect of their declarations. • Lorraine Mattis notified the Corporate Governance Team of a new interest which has been added to the register – member of Primary Care Advisory Group, NHS Confederation. **No other changes** were identified. • Members were also asked to declare any gifts or hospitality that had been received**. No declarations** were made. c) The minutes of the meeting held on 22 March, 26 April and 26 June were **approved** as accurate records of the meeting. d) It was **agreed** to close actions 44, 69, 70, 71, 72, 75, 76, 78, 79, 80 and 81. Actions 73, 74 and 77 are not yet due. In relation to action 64, MC confirmed that Central Bedfordshire would like to take forward an opportunity for an independent review of Place based partnerships. e) The Board Decision Planner was **noted** and members were invited to notify the Corporate Governance team of any additional items for inclusion on the Decision Planner. RM has received feedback from Chairs that they are not receiving updates from ICB Board meetings. Partners were requested to ensure that the information is shared correctly and any suggestions as to how this might be improved be forwarded to MWo.	
2.	**Questions from the Public** Two questions have been received from members of the Public: - one from Councillor Matthew Brennan, Councillor for Dunstable North, in respect of cardiac rehabilitation facilities in Dunstable and Houghton Regis; and - one from Paula Grayson, Chair of Bedfordshire and Luton Fair Play, in relation to opportunities for Foundation Trust Governors to meet with Board members.	

	The full questions and responses given form an appendix to these minutes and will be available on the ICB website.	
3.	**Resident's Story** *Introduced by Catherine Jackson, BLMK ICB Workforce Development Academy, People Directorate* Three health and care apprentices, who are also residents of BLMK, spoke of how apprenticeships have shaped their career to date. Naomi – Occupational Therapist Apprentice, Central Bedfordshire Council Naomi is employed by Central Bedfordshire Council (CBC) and has almost completed her apprenticeship in Occupational Therapy. Naomi wishes to remain at CBC where she has received great support and has had access to multiple resources through the apprenticeship. She also wants to "give back" and will support incoming apprentices on their journey. Misbah, Podiatry Apprentice, East London Foundation Trust Misbah speaks from experience of completing a neuroscience degree at university and a podiatry degree via an apprenticeship. Misbah feels that at the end of the apprenticeship she will be a well-rounded clinician, already comfortable with the working environment. East London Foundation Trust (ELFT), her employer, has used apprenticeships as a means of attracting new colleagues to this hard to fill Allied Health Professional (AHP) role. Kirsty, three Adult Nursing degree apprenticeships, Cambridgeshire Community Services Kirsty joined Cambridgeshire Community Services (CCS) as an Administration Assistant in 2012 and completed three degrees through the apprenticeship route while working at CCS. Kirsty is now the Adult Safeguarding Lead at CCS. Kirsty is grateful for the opportunities at CCS, as circumstances meant she was unable to go to university when she was younger. RM thanked Naomi, Misbah and Kirsty and congratulated them on their progress and wished them well in the future. It is important that students are aware of health and social care apprenticeship opportunities when undertaking GCSEs as an alternative to university. BLMK is already doing work within schools to share the apprenticeship opportunities. MWi suggested there needs to be workforce planning to ensure that apprentice opportunities are ready when the ICB goes to further education or sixth form colleges. SCa finds it difficult to identify apprenticeship opportunities and how to develop people within an organisation. MRo confirmed that there is a network of 100 apprenticeship leaders across BLMK, all working to maximise opportunities. *Catherine Jackson, Naomi, Misbah and Kirsty left the meeting.*	
	SYSTEM STRATEGY	
4.	**Strategic Priorities – Start Well** *Presented by Sarah Breton, Associate Director Children & Maternity Commissioning* RM advised all to watch a video, a link to which had been shared in advance (and is available on ICB website), of a powerful story of a woman who had given birth to twins where there was a very early difference in development of the two children. SB said the paper gives a snapshot of how BLMK is working towards the Start Well strategic priority. There are ambitious plans in the Integrated Care System (ICS) Health and Care Strategy for the 250,000 children and young people that live in BLMK, underpinned by what is happening at Place and the strategic outcome measures that are set by the Children and Young People (CYP) Place-based Partnership Boards. The role of the ICB and the CYP Transformation Board is to bring those Places together and to collaborate and share learning to provide system facilitation and, where it makes sense, to drive the transformation agenda. Co-production is at the core of this work and good relationships have been built with parent carer forums where there is trust, working as equal partners. There is increased collaboration with schools and other educational settings and the Community Services Transformation is a good	

example of this. Both the work on asthma and on children with Special Educational Needs and Disabilities (SEND) has been informed by better information, particularly in relation to inequalities.

There are system risks and challenges, such as waiting times in acute trusts, hospital and community services, and challenges across the health and care workforce for children and young people, particularly in relation to some of the more fragile specialties.

There is strong collaborative partnership working across BLMK, there is clear system leadership and there are priorities on which there are clear plans to deliver on.

Questions and Comments

Audiology - SP stated that 52 weeks is a long time for a child or young person to wait for a hearing appointment and asked what more can be done to save children having to wait so long. SB replied that the focus for the ICB is about the pathways into those services, the assessment and the pathway out of those services. An Oversight Board is being set up to look at the pathways currently in place and to address the gaps. SSt stated that audiology services are delivered by three different providers currently and it is being considered how we can work together. MWi/DC were supportive of bringing audiology teams together and will work to streamline Bedfordshire audiology services.

Mental Health – OK questioned how innovative we are being, particularly around mental health and neurodiversity in children. MWi thanked the local authorities who manage much of the support, particularly through education. There is a national problem to unlock support for these children at an earlier stage, as a diagnosis is the key to getting support. SSt added CCS and schools in Luton have been using an early concern triaging tool and, from an initial 70 children that were assessed, only four needed to go further on the pathway. This demonstrates that some of the things young people are experiencing are normal and for schools to give appropriate support. CCS is running a speech and language pilot where a parent can call in and get either reassurance that everything is normal or for their child to be referred for assessment.

Sharing and Learning – SP asked if we are agile in the way we work to recognise those things that are making a difference and to promote them across all the Places, and also to stop those that are not working. MWi replied that we are sharing experiences and learning from each other and are adapting and adopting as quickly as possible.

Infant Mortality and Stillbirth – LM expressed concern that this appears to be worsening. SB replied that there is a strong correlation with deprivation, particularly in Luton, and there is work to address some of the modifiable factors, such as obesity, smoking in pregnancy and diabetes. The Public Health Information Unit is about to start a piece of work for the Local Maternity Neonatal System (LMNS) on infant mortality. Each of the Trusts individually audits stillbirths and neonatal deaths and also get together in a Shared Learning Forum to discuss learning points.

Outcome Measurement – RM asked whether the strategic target measures are framed in a SMART way and are we measuring the impact of the different initiatives. SB confirmed that the CYP Transformation Board has committed to reviewing the priorities over the next 2-3 years, and to set outcome measures, mindful not to replicate the outcome measures at Place. SB to come back to Board in December to update.

Wider Determinants of Health – SM stated that the wider determinants of health need to be included in the medium-term. SB replied that work is being undertaken around education, housing and youth offending which are the big focus of the Place-based Partnership Boards, where there are SMART measurable outcome measures.

Governance – in response to a question by VM on the governance of the CYP Transformation Board and regular reporting, SB stated that the Chair/SRO is the ICB's Chief Nurse and it is a Partnership Board with partners from across BLMK. As a Partnership Board, it is a forum for deciding areas for change. Five key priorities were determined by this Board and there is regular reporting to it from each of the priority workstreams. SEND annual reports and the Start Well dashboard is taken to the Quality & Performance Committee.

ACTION 82: MWi//DC to look at ways to bring the audiology teams of Bedfordshire into a more streamlined process. **Mwi/DC**

	ACTION 83: SB to update the Board at December meeting on the Start Well strategic priority and to bring high level strategic measures. The Board **noted** the plans in place, progress against these plans and the challenges and risks in relation to achieving the 'Start Well' strategic priority.	**SB**
5.	**BLMK Joint Forward Plan and Operational Plan for 2024/25, Our Priorities and How we Measure Progress** *Presented by Maria Wogan, Chief of Strategy & Assurance* The paper brings together the Joint Forward Plan (JFP) with the Operational and Transformation Plans for 2024/25. It builds on the Board seminar held in January 2024. MWo confirmed that a balanced Financial Plan for 2024/25 had been submitted, although it contained c£55m of unmitigated risk. The Operational Plan contains finance, activity and workforce plans for the system. There are two national targets that the system cannot achieve this year. These are: - 65 week waits where it is expected that there will be 797 people waiting in September and 181 waiting in March 2025. There is comprehensive work and a robust plan to address this with the support of regional and national colleagues; and - 6 week diagnostics – it was declared that BLMK ICB would achieve 85% performance by March 2025, compared to 42.4% last year, for the 6-week diagnostics standard, but is still below the 95% national target. Online additional diagnostic capacity is in plan this year to support this challenge. The Workforce Plan is based on a 0.1% increase in the acute trusts' total workforce, representing a 1.54% increase in substantive staff and a 10.56% reduction in bank and agency staff. In terms of governance, there are fortnightly meetings with Acute Trusts' Chief Executives (CEOs), Directors of Finance (DOFs), Chief Operating Officers (COOs) and Chief People Officers (CPOs) to address the unmitigated risk and to give assurance around delivery of the plan. There are regular meetings with Mental Health Learning Disability and Autism (MHLDA) Trust colleagues, which have been instrumental in developing the plan. There is a level of unmitigated risk in the mental health area but there is work to address that through the new BLMK MHLDA Collaborative. There was also a meeting last week of Community Trusts in relation to work across the sector to support delivery of the plan. Full details of the governance arrangements are set out in Appendix A of the report. In terms of transformational priorities, following January's Board seminar the 40 plus transformation schemes in BLMK being led by the ICB were reviewed and reduced to 11 medium-term priorities, which sit as part of a wider BLMK transformation portfolio that has four agreed pillars: Episodic Care & Prevention, Planned Care & Support, Complex Care and Enablers. There are 46 priority programmes grouped under these four pillars, led by Bedford, Central Bedfordshire, Luton, and Milton Keynes Places, Bedfordshire Care Alliance (BCA), MHLDA Collaborative, ICB, Bedfordshire Hospitals Foundation Trust (BHFT) and Milton Keynes University Hospital (MKUH). The report gives a full system perspective, although the report is structured in such a way that information can be identified for a particular Place or Trust. It is intended to have strategic outcome measures for the 11 ICB priorities by the end of November. There will also be a Board seminar in October with the IHI to support the system with this work. The Board has agreed a Data Pyramid approach to measuring outcomes, where the top of the pyramid describes the overall strategic outcome target for the population, the second layer measures strategic outcomes related to transformation work and the bottom layer gives performance data. Verto is the project management system where all of these projects will be loaded onto and which is accessible to the ICB and all partners across the system. Within the plan, there are 140 key milestones due for delivery between now and the end of the year and 90% of these are on track for delivery. Where there is slippage, support will be given. RM recognised the work involved with this project and welcomed the considerable progress.	

	Questions and Comments RM stressed the importance of ensuring that everybody is striving for the same end goal, and where the silos do not make sense, these need changing. MWo responded that each of the strategies is underpinned by a delivery plan, which will fall into the Portfolio Report so that they will align with the other work. It is expected to produce a more detailed refresh of the JFP to support the strategic priorities, as the context has changed and the system is better informed. In response to a question by MG, MWo added that the interdependencies between projects/programmes are picked up in the Portfolio Report that includes who is leading each project, the key players and key stakeholders involved in delivery. In response to a question by OK as to whether the data pyramid approach allow us to see whether we are achieving our strategic objectives and, if not, what the consequences are and what do we do next. MWo replied that all pieces of work must have clear aims and defined measures. SSt added that there will be an element of holding our nerve that the process measures are working against the longer-term strategic measures that we will collect from the Office of National Statistics (ONS). The transformation programmes will have a shorter time frame of 9-18 months so movement will be visible earlier. In response to a question by MTa on how this framework fit into the Insights Network, MWo responded that a lot of the outcome measures are resident focussed, which very much link to the Insights Network in terms of getting insights into whether or not the outcomes are being achieved as well as having the opportunity to talk to residents about what the right measures for them are. SP welcomed this approach and recommended Board members to look at the appendices, a piece of structure that has been requested for a long time. The Board **noted**: • the BLMK Operational Plan for 2024/25, as submitted to NHS England (NHSE) on 12 June and the supporting governance arrangements; • the transformation priorities for 2024/25 as agreed by the ICB Executive Team which sit as part of a wider system transformation programme incorporating transformation priorities identified by Places, Collaboratives and Trusts; and • the developing BLMK Portfolio Report as a means of tracking the implementation of transformation work across BLMK. • The Data Pyramid as a framework for bringing together performance data alongside transformation programme-specific and system-wide outcome measures in BLMK.	
6.	**Review and Refresh the Working with People and Communities Strategy** *Presented by Maria Wogan, Chief of Strategy & Assurance* MW thanked Lorraine Mattis, Chair of Working with People & Communities (WWPAC) Committee, and all members of the committee for their help in developing the ICB's approach to working with people and communities. Following on from the Denny Review and the Big Conversation, with wide engagement led by partners across the system, the refreshed WWPAC strategy and priorities have been developed. Going forward, the focus is to implement learning from the Denny Review, embedding co-production into all of the work and learning from insights and using them to inform the decision making. It was proposed that a System Insight Network is established and the Working with People and Communities Committee is dissolved. The Insights Network will report formally to the Quality & Performance Committee (Q&P) on a quarterly basis. LM, Chair of WWPAC, thanked the ICB for its continued support and investment. SP, Chair of Q&P, confirmed that these proposals have been discussed at Q&P and that the committee supports the proposals. The Board **approved**: • the refreshed Working with People and Communities Strategy; and • the proposal to dissolve the Working with People and Communities Committee and establish a new System Insights Network. The Insights Network will report into the ICB's Quality and	

	Performance Committee, which will in turn provide continued assurance to the ICB Board that it is delivering on its statutory duties to involve (Q13; 14Z44, Health and Social Care Act, 2022). The Governance Handbook will be amended accordingly.	
7.	**BLMK ICS – 2023 System Staff Survey Results** *Presented by Martha Roberts, Chief People Officer* MRo reported that a number of BLMK's NHS providers have rated top on the latest annual staff survey, published in March, reflecting the positive work of colleagues. Local authority staff survey results are not available but it is hoped to include these in the future. The design of the report aligns to the NHS People Promise, which is a piece of work co-produced with staff to ensure that we are measuring what they would like us to measure, as well as morale and engagement. Compared to the rest of the East of England, when averaged out, BLMK ICS's scores are either at or better than the average for the region. The scores for CCS, ELFT and CNWL represent only those staff that work within BLMK. There is work underway to align the Staff Survey Results into the People Board subgroup and to review the People Strategy, and these will be discussed with system and trade union groups. *Comments and Questions* RG – community and mental health providers seem to have very strong scores overall, which is not the case in other systems and asked what we can learn from that. MRo will go back to the workforce group and let RG know. MWi – A useful evidence-based tool where we should drill down into the data to look at what is emerging in terms of productivity and quality. VM expressed concern that in 4.22 staff morale and engagement at the ICB appeared to have been lower than providers, MRo replied that at the time of the staff survey last year, ICB staff were in the process of a change process, a time of uncertainty. ABo welcomed the really positive results and, following on from the apprenticeship successes, and asked what other opportunities are there across the organisations for apprenticeships or work shadowing. MRo stated there are already some good examples of work shadowing in the system and encourage others to take advantage of this. DC stated that as a provider, this is the most powerful data, giving real insight. Bedfordshire Hospitals Foundation Trust (BHFT) uses this to try to understand at a granular level the variations across different departments. LM was pleased to note that staff morale and engagement is higher than the national average, but it is clear that there are adverse outcomes for black and minority ethnic staff, as well as staff with long term conditions or disability and asked how this is being addressed. MRo replied that the Workforce Race Equality Standards (WRES) data and the Workforce Disability Equality Standard (WDQS) have been around for 10 years. There is a lot of work undertaken by individual organisations to make sure that we understand and hear the voice of those colleagues. OK stated that staff, particularly in the ICB, feel that there are limited opportunities for them, and would welcome feedback through the Board as to what is being done to address this. **ACTION 84**: MRo to update the Board on progress on issues arising from the staff survey and in particular in relation to inclusion and diversity. The Board **noted** BLMK ICS staff survey results; and the next steps identified in the report.	**MRo**
8.	**Analysis of BLMK Acute Hospitals Emergency Activity** *Presented by Michael Ramsden, Associate Director for Delivery* The paper updates the Board on the preparations for Urgent Emergency Care (UEC) winter planning, and the appendix contains an analysis of people presenting to Accident & Emergency (A&E) as well as the reasons for attendance and admission.	

Between 2022/23 and 2023/24, attendance levels were consistent. However, there has been a rise of approximately 7% between April to May 2023 and between April to May 2024 (rises of 24% in Bedfordshire Hospital, 8% in Luton & Dunstable Hospital and 2% at Milton Keynes Hospital). Mental health, emotional distress and psychological presentations have increased by 22% in 2023/24 compared to the previous year.

The data also highlights opportunities to re-examine pathways and consider whether care could be delivered in alternative ways, such as through community or surgical assessment units. Examples of this include managing musculoskeletal (MSK) injuries, where the highest attendances were boys between the ages of 10 and 14, and these could be navigated through Urgent Treatment Centres. It is noted that, of the presentations for psychological and behavioural change complaints, 57% were known by mental health services. No significant treatment was received by 30% of children aged 0-18 as part of their A&E attendance.

The report refers to "Alternatives to Emergency Departments" (At-Ed) audits, which are providing some valuable insight into visibility of pathways across Primary and Secondary Care can be improved, to navigate patients to the right place first time.

As in previous years, BLMK will be expected to deliver a system-wide Winter Plan. The paper outlines several strategic priorities which are already in delivery, and this will help inform the longer-term planning approach. These include a focus on improving A&E performance and category 2 ambulance response times and a review of mental health emergency pathways in Bedfordshire

Analytics - the data in Appendix 1 of the report will include further analytics on care homes and end of life care, the outputs of At-Ed audits will be reviewed and there will be learning from the successful Bedfordshire Care Alliance decompression event, which has supported significant flow improvement through the hospital trusts and with great collaboration with community providers.

Prevention - the focus will be to increase knowledge and utilisation of the Voluntary, Care and Social Enterprise (VCSE) sector, to improve flow and emergency care pathways, to build on the good collaboration working in the Improving System Flow Group in Milton Keynes and the Bedfordshire Care Alliance to further strengthen UEC pathways

Questions and Comments

DC – *Bed Capacity and Population Growth* – it is recognised that the old concept of winter has changed as pressure is increased throughout the year and that there are longer periods of pressure throughout each day. It seems that the acuity of patients presenting to A&E has increased, which is consistent with the ageing population, particularly at Bedford Hospital. The higher than average population growth in BLMK is a real concern. Work is being done in terms of capacity and funding has been received for Same Day Emergency Care (SDEC) capacity. It was not recommended to increase the bed base of the acute hospitals, but to concentrate on reducing patients at A&E.

JH – For a population that will more than double in the next 20 years, there will need to be more bed capacity. MKUH is one of the 40 proposed new hospitals, and the only one that will increase bed capacity, as the Government has recognised the scale of population growth in Milton Keynes. It is reassuring to see in the latest regional performance reporting that BLMK stands out as one of the systems with a very good length of stay for its patients.

OK —reflected that the report recognised that A&E attendee rates do not necessarily relate to inability to get GP appointments. However, it was questionable whether A&E is the best place for mental health patients to present.

LS – A&E represents a place that anyone can go to and, with more awareness around mental health and neurodiversity, people with these conditions feel that they can present to A&E whereas they may not have done previously. People also present to A&E for other health reasons but may need more support due to also having a mental health condition. This is a multi-faceted issue with mental health hospitals functioning at over 90% capacity and issues relating to housing and step-down accommodation as common factors for mental health patients. LS stated that she would not want to see mental health patients singled out in terms of attending A&E. It is hoped that the work of the new BLMK Mental Health Learning Disabilities & Autism (MHLDA) Collaborative will be able to focus on these issues.

	MWi – *Understanding and Making Use of the Data* - agree that the figures on correlation between GP appointments and A&E attendance is interesting, which is different to what had been expected. Also interesting to note that only 19% of Central Bedfordshire patients actually present to hospitals outside the area, of which half go to Lister Hospital. MRa stated that data insight will be used in the winter planning approach this year. *Vicky Head arrived.* MG – *Scope and Governance* - More analysis is needed in terms of the key cohorts and understanding the cause, effect and interventions required. The report felt more like an "acute board" report than a "system board" report, would have expected more about other parts of the system including local authorities, primary care, mental health. MRa replied that this gave a summary of the challenges within the acute hospitals, but it does need to develop into a more system-based approach to winter planning. RM – *Wider Engagement* - last year there was engagement with organisations such as Age UK and British Heart Foundation, who supported the campaign to keep people well and avoid admissions. Request to include this in the process. In response to a question by VM regarding increase in demand and ensuring plans were in place for next winter to address this, MRa responded that year on year presentations have been flat, apart from April and May where there was a 7% rise at a time when the whole system was challenged. MT – *Funding to Match Population Growth* - In Bedford Borough, there is 20% population growth against the national average of 6%. The ICB needs to ask for more money in the planning process to get ahead of the population curve. Similar pressure is on local authorities to manage its increased. This will be discussed in the infrastructure Strategy item in the private meeting agenda. **ACTION 85**: The Board to receive a winter planning update in September. **ACTION 86**: Engagement and insight with outside organisations such as Age UK and British Heart Foundation into the winter planning. The Board **noted** the Analysis of BLMK Acute Hospitals Emergency Activity Report. *Michael Ramsden left the meeting.*	**MRa** **MRa**
	SYSTEM ASSURANCE	
9.	**Audit & Risk Assurance Committee (ARAC)** **Chair's Report –** *Presented by Dr Vineeta Manchanda, Chair of Committee* - Meeting held 19 April and further meeting on 26 June to review the Annual Report and Accounts, which have now been approved by the Board; - **Alert** – nothing to alert to the Board; - **Advise** – received a number of internal audit reports, all moderate assurance, with no concerns: - The **Continuing Health Care (CHC) report** showed that the reason for the overspend in 2023/24 was the unanticipated increased demand, price increases and higher than expected complexity. Insufficient staff and problems with reliability of data meant that some of the CHC standards and targets were not met. More work is needed to ensure that people coming from care homes and acute trusts are not put onto fast track unnecessarily; - Assurance on the **Safeguarding internal audit report** was moderate, where there is increased workload but insufficient resource; - Concerns were raised with the committee that the increasing workload may impact on the **Information Governance** team's ability to carry out its statutory function; and - There was a deep dive into UEC, where good progress has been made to develop a more granular and system-wide risk assessment, including the development of draft key risk indicators. The committee will consider this further at its meeting on 26July.	

	System Risks and Board Assurance Framework (BAF) *Presented by Maria Wogan, Chief of Strategy & Assurance* The focus has been on getting more granular risk assessment, using the dynamic risk management approach. This has been trialled on UEC and VCSE risks, progress on which is given in the paper, and will be reported to ARAC on 26 July. Positive feedback has been received from auditors, recognising that the system is leading the way in terms of partners engaging on the system risk agenda and working together to develop key risk indicators for a system. The Chief Executives' Group yesterday agreed that the next two risks for system risk assessment will be cybersecurity and the impact of the Provider Selection Regime on the contractual landscape in terms of capacity. 1. The Board **noted** the Audit & Risk Assurance Committee Chair's Update Report. 2. The Board **noted** the System Risks and BAF update including the progress with the more detailed risk assessments undertaken with partners for the UEC and VCSE risks, the future work programme including prioritisation of a system risk assessment for the cyber security risk and the impact of the Provider Selection Regime.	
10.	**Bedfordshire Care Alliance (BCA) Committee Chair's Update** *Presented by Shirley Pointer, Chair of Committee* - Projects have been reset for the BCA – two are progressing well and with Senior Responsible Officers (SROs) identified and milestones; the others are in earlier stages of development, with Project Managers assigned. - The committee's Terms of Reference (ToRs) were presented for approval but it was decided to reflect on whether the purpose of the BCA is appropriately articulated in the ToRs. - The risk to delivery of projects is making sure that the right stakeholders are around the table so that they are properly defined with resources allocated to deliver. DC felt that this links strongly to the portfolio management tool, which will clarify where work is being done and minimise duplication. Getting the governance right is key, particularly with the complexity of having three local authority boroughs and the BCA. The Board **noted** the Bedfordshire Care Alliance Committee Chair's Update.	
11.	**Quality & Performance** **Quality & Performance Committee (Q&P) Chair's Update** *Presented by Shirley Pointer, Chair of Committee* - Q&P Committee is maturing well, with the items being brought to the committee representative of the pressures across the whole system, not just the NHS element. - Many of the issues listed in the Assure and Advise areas of the report appear elsewhere on today's agenda, which should give assurance that the issues that the Board are looking at are being considered in more detail at Q&P **Performance Report** *Presented by Maria Wogan, Chief of Strategy & Assurance* MWo noted the achievement of the A&E 4-hour standard, dementia diagnosis rate, cancer faster diagnosis standard and the virtual ward roll out as a system. Waiting times, particularly for elective treatment, continue to be a challenge and both acute trusts are working on action plans to address these. The report highlights challenges around mental health performance in terms of Serious Mental Illness (SMI) health checks, Talking Therapies, out of area bed days and learning and disability health checks, and particularly in Milton Keynes for children and young people. The BLMK MHLDA Collaborative will be focusing on this. The Board **noted**: - the Quality & Performance Committee Chair's Update; and - the Performance Report.	

12.	**Finance & Investment** **Finance & Investment Committee (F&I) Chair's Update** *Presented by Manjeet Gill, Chair of Committee* - The last meeting focussed on more visibility of the procurement timeline for all contracts and obtaining assurance of the key activities and strategic commissioning in terms of market development and the role of other providers and alternative models of care before going out to procurement. - More assurance was sought of the shared ownership by key leaders of partner organisations to ensure consistency in how the funding is used across BLMK. - Independent advisers are being used to share best practice in implementation of Better Care Funds to maximise the resource and ensure transformation is included. - Compared to some of the national positions, the system achieved a positive outturn in breaking even. However, the underlying deficit last year grew from £22m to £35m which is challenging. Many of the efficiencies were non recurrent. - The system achieved the Mental Health Investment Standard. **ICS Finance Report Month 2 (May 24)** *Presented by Dean Westcott, Chief Finance Officer* DW said the ICB had submitted a balanced plan, with BLMK being one of the few systems in the country to do this. Efficiencies are required of just over 6% at £106m, and unmitigated risks of circa £55m. There has been a challenging start to the year as at month 2, the system was £3.4m adverse to plan, and at month 3, that has increased again although the rate of increase has slowed, leaving the ICS £6m off plan. Premium staffing costs because of staffing escalation areas and loss of income are drivers of the deficit for the first three months of the year. The System forecast remains to break even, but real focus will be required to achieve this. There is a fortnightly meeting to review acute sector productivity, mental health services and community contracts and a Chief Executive Oversight Group that meets fortnightly. MKUH has a Transformation Board, BHFT has put in place a Productivity and Efficiency Board and the ICB has the Finance & Improvement Group. MKUH has brought on board a productivity partner to help support not only the delivery of the in-year Cost Improvement Programme (CIP), but to take a longer term look at productivity and enhancing their PMO infrastructure. As a system, the plan is to maximise the Elective Recovery Income which is partially incorporated in the system plans and must be achieved. The recent decompression exercise in Bedfordshire made an additional 100 beds available, which has already positively impacted BHFT. There have been two regional meetings this week to provide assurance on the system plans and actions are being taken. A recovery trajectory that shows things getting slightly worse in July and then steadily getting better towards the end of the year has been agreed with CFO colleagues and been shared with the regional team. DW confirmed that Service Development Funding (SDF) is prescriptive and must be spent on what it is designated for, if used otherwise, it will be clawed back. MTo asked how much auditing is there on expenditure, was it worth it and was it efficient? DW confirmed that it is continually reviewed internally, and that the ICB is subject to external audit annually, part of which is a Value for Money (VFM) Review. The Board **noted**: - the Finance and Investment Committee Chair's Update; and - the ICS Finance Report Month 2 (May 24).	
13.	**Primary Care Commissioning & Assurance Committee Chair's Update** *Presented by Alison Borrett, Chair of Committee*	

	• *Advise and Assure* **–** Primary Care Delivery group reported that the GP practice closure, arrangements to transfer patients went smoothly, despite the closure taking place quickly. PCCA has asked for lessons learnt so that best practice can be shared. • *Dental appointment capacity risk* - work is being done with providers to maximise NHS appointments, although it will not be sufficient to cover those dentists that wish to withdraw from NHS contracts. • The internal audit on Dental Contracting arrangements received a "substantial" rating for both design opinion and design effectiveness. • The Primary Care Medical Educational Expansion Programme is now under the ICB's remit from NHSE. An innovation led by the ICB is for pharmacy students to be offered paid placements over the summer. The Board **noted** the Primary Care Commissioning and Assurance Committee Chair's Update.	
14.	**Working with People & Communities Committee Chair's Update** *Presented by Lorraine Mattis, Chair of Committee* The Board earlier agreed for this committee to be dissolved and for the Insights Network to be established, with its effectiveness reviewed after 12 months. The Board **noted** the Working with People and Communities Committee Chair's Update.	
	ICB Organisation Decisions, Governance and Assurance	
15.	**Chair's Report** *Presented by Dr Rima Makarem, Chair* The Chair has no update for the Board, which has not been included within other parts of the meeting.	
16.	**Chief Executive Officer's Report** *Presented by Felicity Cox, Chief Executive Officer* FC reported that BLMK had its annual review meeting with the NHSE regional team on Wednesday. Whilst the review itself will not be published, it will form part of an assessment that will be published in the autumn. FC wished to thank the partners and Vicky Head, in particular, who represented all four Public Health teams. NHSE recognised the hard work that had been required to get to financial balance last year and to develop balanced plans for this year, while acknowledging the challenges as mentioned in the finance report. Strong Place working, a good population health approach and population health intelligence were all recognised, as was the hard work involved with taking on responsibility and leadership in the Specialised Commissioning area. There were a couple of areas where NHSE were keen for us to do more as an ICB: • to tighten our collective approach to oversight to improve delivery; • to avoid duplication or surprises; and • to improve sharing our best practice across the region and nationally. A letter from the region to the board will be circulated, and it will be forwarded to the national team and benchmarked against other system's reports. At that point it will be published. The Chief Executive Officer's Report was **noted.**	
17.	**Partner Governance Reports** **Bedford Borough** – *presented by Alex Wrack, Place Lead Bedford Borough* The Council agreed a recommendation from the Health and Well Being Board (HWB) that representatives from local NHS provider trusts and the voluntary sector will be invited to attend the HWB as advisory members, and that practice has now started. The focus at Place and Place Board has been on delivering and updating Place priorities, as outlined in the paper, based on population data.	

A neighbourhood project has been piloted in the Caldwell area, funded by Carers in Bedfordshire, in an attempt get more carers coded registered on the General Practice system but also enabling them easier access to Carers in Bedfordshire support. As a result, there has been an increase of 72%, representing 117 people, in the number of people now coded onto the system as a carer. It is hoped that this project can be rolled out across Bedford Borough and into Central Bedfordshire. JH recommended using the NHS App to send text messages for free.

Luton – *presented by Faith Haslam, Place Lead Luton*
Luton Place Board continues to meet on a monthly basis, most recently focussing on ownership of the programme by all partners who are engaged in the Place Board of the programme. Feedback is positive and a more structured way of reporting is being developed.

At the last Health & Wellbeing Board, the ICB updated on the Luton Complex Care and Frailty Programme. Future ICB updates at this Board will be on the progress made against the Luton 2040 pledge.

The ICB visited the Biscot Peace and Wellbeing Hub which is a joint initiative and an example of how relationships are built. Some of the innovative projects, such as the Biscot hub, were shared with the Institute of Healthcare Improvement (IHI) and NHS Confederation recently and received very positive feedback.

The Luton Integrated Neighbourhood Collaborative (LINC) has been established to lead on strategic planning and accountability for delivery of key integrated neighbourhood projects.

The LINC is aligned to the key pillars of the Fuller Programme, the Luton Population Wellbeing Strategy overarching vision and priorities and the Luton 2040 priorities.

Milton Keynes – *presented by Maria Wogan, Place Link Director, Milton Keynes*
"MK2028" sets out Milton Keynes' ambition for the next three years. The set up of the MK Primary Care Alliance as an umbrella organisation to act as "one voice" for Primary Care is welcomed.

There has recently been CQC and Ofsted inspections in Milton Keynes and it was noted that positive progress had been made to improve support children and young people with SEND.

It has been agreed to run a pilot to support children and young people with obesity, using some of the inequalities funding, and to support the implementation of a single point of access for children and young people's mental health. This is very much in response to feedback from residents and work undertaken as part of the MK2028 vision and the Bletchley Pathfinder work.

There have been well attended events showcasing and sharing the community assets in Bletchley and there is some exciting work starting with schools to support families with complex issues through a multi-disciplinary approach.

OK expressed thanks to the ICB, and in particular NP and the Primary Care team, for supporting the establishment of the MK Primary Care Collaborative.

Central Bedfordshire – *presented by Marcel Coiffait, Chief Executive, Central Bedfordshire Council*
In Sandhills Primary Care Network, there is a pilot for people with substance misuse and mental health issues, to access and benefit from physical activity and, ideally to then engage them on the pathway to a recovery programme. The programme has been co-designed with people with lived experience. A potential cohort of participants has been identified and the project team is making contact with them.

Titan Primary Care Network has a pilot to deliver personalised support for people with Chronic Obstructive Pulmonary Disease (COPD) and is targeted at people who are struggling to manage their condition, to prevent exacerbations, improve their education around symptom management and encourage adherence to their medication.

Feedback on both pilot schemes will be brought back to the Board at a later date, but initial feedback has been positive.

General Questions and Comments

	LM stated there is a lot of great work happening in the system at all four Places and pilot schemes are proving successful and asked how good practice is shared. In response MW stated that the four Place Link Directors meet every week to share what is happening our each of the Places and spread learning. VM stated all reports were clear and gave a good sense of what is happening. Some of the initiatives seem to be inexpensive, it would be useful to have an idea of what these pilots are and which are "Business as Usual" (BAU). SSt replied that data is used to ascertain whether the pilot is achieving the outcomes specified and can therefore be expanded. VM asked whether training on Verto could be made available for NEMs. SP requested that things that are coming up, in particular that are relevant to Bedfordshire, are raised at BCA level, either through Place Directors or representatives. MTa asked that Place Link Directors consider the benefits and disbenefits of local Healthwatch and VCSE representatives being represented on Place Boards, as this would connect them better to the pilots and priorities of the Places, where they can lend their support and experience. **BLMK Mental Health Learning Disabilities & Autism (MHLDA) Collaborative –** *presented by Ross Graves, Chief Strategy Officer CNWL* The inaugural meeting of the Collaborative Committee in shadow form was held on 11 June. The draft Terms of Reference were reviewed. The ongoing work on the operating model of the "one team approach," working across the ICB, ELFT and CNWL was discussed and endorsed. There is significant progress on closing the financial gap with the core priorities and delivery plans being monitored by the committee and taken forward by the MHLDA programme that is currently being brought together from existing BLMK work programmes. The value that service users and carers bring to the table is recognised, and three service users attended the shadow committee meeting. In response to a question by SCa regarding the MHLDA priorities, RG confirmed the priorities for the MHLDA collaborative, which were discussed at the meeting were: 1) development of sustainable early intervention and crisis recovery pathways across children and young people, and adults; 2) Early local diagnosis and support for people with autism and ADHD; 3) Sustainable recovery focused models of care for people with complex needs; 4) Capital development in core services; and 5) Improving physical health access and outcomes for people with serious mental illness, learning disability and autism. Discussions are ongoing in Place and arrangements for delivery in each area will be slightly different. A broader communications plan will be developed. **BLMK Health & Care Partnership** - *presented by Martin Towler, Co Chair BLMK Health & Care Partnership* The report was taken as read, and MTo had nothing further to add. **ACTION 87**: Place Link Directors to discuss Healthwatch and VCSE representation on the Place Boards. **ACTION 88**: Priorities for the MHLDA Collaborative to be circulated to members and attendees. **ACTION 89**: Develop a broader communication plan in relation to MHLDA Collaborative. The Board **noted:** - the reports from the four Place Boards, the shadow BLMK MHLDA Collaborative and BLMK Health and Care Partnership; and - the update on the Creating a Fairer BLMK event on 17 May 2024.	**MW ABr NP SSt** **RG** **RG**
18.	**Corporate Governance Update** *Presented by Maria Wogan, Chief of Strategy & Assurance*	

	The proposal to request NHSE to reduce the quoracy for the Board from 50% to 9 was discussed and an amendment was made that at least one NEM that is a member of F&I attends Board meetings. The Board: • **approved** the BLMK Mental Health Learning Disability and Autism Committee Terms of Reference and update to the Governance Handbook; • **approved** the revised Finance and Investment and Quality and Performance Committees' Terms of Reference and to update the Governance Handbook; • **agreed to** request NHS England to approve a change to the quoracy of the Board of the ICB approve in the Constitution to nine members rather than 50% and for a Non-Executive Member who is a member of F&I to be present; • **noted** the submission of the Annual Report and Accounts 2023/24 to NHS England, as agreed at the Extraordinary Private ICB Board meeting on 26 June 2024; • **approved** the extension of the review date for the Conflicts of Interest and Standards of Business Conduct Policy to 31 December 2024, to enable the national guidance, that is yet to be published by NHS England, to be reflected in the revised policy; • **noted** the compliant Fit and Proper Person Framework submission to NHS England in relation to the ICB Board on 28 June 2024 noting the mitigations included in the report; and • **approved** the amendment to the ICB's Scheme of Reservation and Delegation (SoRD) to delegate responsibility for signing-off the Better Care Fund for each place from the ICB CEO to the ICB's Place Link Director, following a review of the submission by the ICB Executive Team and appropriate place-based governance.	
19.	**2024/25 Section 75s (non Better Care Fund)** *Presented by Kathryn Moody, Deputy Chief Operating Officer* KM reminded the Board that, under Section 75 of the 2006 NHS Act, the ICB is encouraged to establish pooled budgets to support integrated commissioning, and that there are integrated commissioning arrangements with all four of BLMK's local authorities. Two S75 agreements are brought to the Board for approval today: - S75 for pooled funds with Luton Borough Council; and - S75 for Integrated Community Equipment with Milton Keynes City Council. These agreements have been jointly developed between the ICB and local authority colleagues, having previously been signed by the local authorities and F&I, where they were recommended for Board approval in line with the ICB's Standing Orders and Scheme of Reservation and Delegation (SoRD). It is recommended that a review is undertaken of the percentage cost share during 2024/25 to inform the agreement for 2025/26. The Luton agreement still needs some work in terms of the wording and bringing it up to date. If any changes are suggested during 2024/25, they would be brought as a Deed of Variation for approval. • SP suggested that it would be useful to have an overview of these arrangements as there was a wide variation under these agreements. VM requested more detail of the total amounts in all s75 agreements which will be circulated outside the meeting. • MWi – asked that point 4.4 is corrected. It states "the integrated equipment (for which funding is provided through the BCF)" but not all integrated equipment is funded through the Better Care Funds. **ACTION 90**: Consider how the Board can have a broad overview of S75 arrangements. **ACTION 91**: Amend 4.4 of the Luton agreement to take into account that not all integrated equipment is funded through the Better Care Funds. The Board **approved** the following Section 75 agreements: - Pooled funds S75 for Luton Borough Council (LBC), with the change regarding integrated equipment which is not all funded through the Better Care Fund; and - Integrated Community Equipment S75 for Milton Keynes City Council (MKCC).	**KM** **KM**

Closing Items		
20.	**Communication from the Meeting** Communications from the meeting will be written up and shared with partners. **Action 92**: MSu - Communications from the meeting to be shared with partners.	**MSu**
21.	**Meeting Evaluation** • RM – reflected that it was a full agenda; • SCa – content very good but a lot to get through. Quite difficult to navigate papers with appendices separate; • RM – important that papers are detailed enough for someone to understand without having to look at the appendices • MWi / LC – This chamber is not ideal as you can't see everyone and are reliant on microphones and roving cameras to see or hear who is speaking, good to rotate around the different areas, but better to be somewhere when we can all see each other; • MWi – there was a lot of "assurance based" content; and • LC – a lot of public assurance of what is going on at committee's underneath and governance decisions. The other items were not clear on their purposes. Recommendations and actions need to be clearer.	
22.	**Any Other Business** The Chair thanked Marcel Coiffait, Chief Executive Officer, Central Bedfordshire Council, for his hospitality today. **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. *The meeting finished at 12.40*	

Next meeting
Date: Friday 27 September 2024
Time: 09.00 – 13.00
Venue: Luton Council Chamber

Approval of Draft Minutes by Chair only:		
Name	**Role**	**Date**
Dr Rima Makarem	Chair	15 September 2024

APPENDIX A
BLMK Board 19/7/24

Question 1:

"When will BLMK ICB follow other ICBs in inviting Lead Governors and Deputy Lead Governors from their FT providers to quarterly meetings with some Board members?"

From Paula Grayson, Chairman, Bedfordshire and Luton Fair Play

Answer (responded at 19.7.24 Board in Public):

Response from Dr Rima Makarem, Non-Executive Chair, BLMK ICB

"We've had annual meetings with all governors over recent years. I've also presented to governors at individual NHS organisations when invited. Their CEOs are members of the board and should be their primary point of contact and should be feeding back to them (and ensuring their feedback is fed back to the ICB where relevant). Their chairs are members of the ICP and should also act as a liaison point. All governors are also invited to observe ICB meetings held in public.

If there are specific topics that governors want to discuss, they may ask for a meeting via their chairs and directors of corporate governance."

Question 2:

"I am a Central Bedfordshire Councillor for Dunstable North and I have been contacted by residents with regards to the lack of Phase 4 Cardiac Rehab available within the Dunstable and Houghton Regis area. I have been informed that other areas do have funding for this service, and I would like to know what is being done to address this postcode lottery for my residents who must travel great distances to access this service. Will you commit to funding this service for the residents of Dunstable and Houghton Regis?"

From Cllr Matthew Brennan, Central Bedfordshire Council, Dunstable North Ward

Answer (responded at 19.7.24 Board in Public):

Response from Nicky Poulain, Chief Primary Care Officer

"*I would like to thank Councillor Brennan for his question regarding Phase 4 Cardiac Rehabilitation and I have spoken to him about the issues faced by residents in Luton, Dunstable and Houghton Regis.*

Cardiac rehabilitation phase 4 is the maintenance phase of cardiac rehabilitation which happens following a cardiac event, like a heart attack. It is designed to help individuals who have completed Phases 1-3 of NHS guided cardiac rehabilitation to maintain their progress and continue to live a heart-healthy lifestyle. After completing phase 3 classes, patients can be referred onto structured community-based classes, referred to as phase 4 classes.

The Central Bedfordshire Place team is working closely with Public Health and Central Bedfordshire Council colleagues to examine the current provision and whether the services can be provided nearer to Dunstable and Houghton Regis. Cardiac rehabilitation is an integral part of the prevention agenda which we are all committed to, in order to ensure residents live in better health.

I will work with Central Bedfordshire colleagues and with Councillor Brennan, who has confirmed that he is happy with this."

Integrated Care Board MASTER Action Tracker as at 2.9.24

Meeting in PUBLIC

Bedfordshire, Luton and Milton Keynes Integrated Care Board

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 due date - RED
In Progress	**In Progress.** Outstanding - actions made to progress & on track to deliver due date - AMBER
Not Yet Due	Not Yet Due - BLUE
COMPLETE: Propose closure at next meeting (insert	**COMPLETE** - GREEN
CLOSED (dd/mm/yyyy)	Actions to be marked closed and moved to 'Closed Actions" Tab once approved for closure at meeting.

Action No.	Meeting Date	Agenda Item	Action	Action Owner	Past deadlines (Since Revised)	Current Deadline	Current Position (latest update)	RAG
64	08/12/2024	Carnall Farrar (CF) Review of the Development of Health and Care Integration in Milton Keynes	MC, LC and RP to consider whether a Carnall Farrar type review would be helpful for their development of place.	Marcel Coiffait/Laura Church/Robin Porter	22/03/2024	27/09/2024	24/1/24 - RP (Luton) confirmed that such an exercise would be useful to ensure a clear purpose and delivery. 12/2/24 - LC (Bedford Borough) confirmed that they would also like a similar piece of work to be undertaken. 10/6/24 - ABr has contacted MC to see if there is interest at CBC. 19/7/24 - MC confirmed in Board meeting that Central Bedfordshire would also like to take this forward. 22/8/24 - MW - an independent review of the place arrangements in Bedford Borough, Central Bedfordshire and Luton and the Bedfordshire Care Alliance is beign commissionined. The outcome will be reported to the Board.	**COMPLETE: Propose closure at next meeting (27/9/24)**
73	22/03/2024	Health Services Strategy	To be brought back to the Board in six months' time	Sanhita Chakrabarti		27/09/2024	On agenda for September meeting.	**COMPLETE: Propose closure at next meeting (27/9/24)**
74	22/03/2024	Non Emergency Patient Transport	To be brought to the Board in September	Kathryn Moody		27/09/2024	Update to be included in Chief Executive Officers' report at September meeting.	**COMPLETE: Propose closure at next meeting (27/9/24)**
77	22/03/2024	Q&P Report	To include services provided by VCSEs	Maria Wogan / Sarah Stanley		27/09/2024	24/5/24: These will be included from September.	**COMPLETE: Propose closure at next meeting (27/9/24)**
82	19/07/2024	Strategies Priorities: Start Well	To look at ways to bring the audiology teams of Bedfordshire into a more streamlined process	Matthew Winn / David Carter		27/09/2024		15/8 - emailed DC/Mwi, chased 30/8
83	19/07/2024	Strategies Priorities: Start Well	To update the Board at December meeting on the Start Well strategic priority and to bring high level strategic measures.	Sarah Breton		13/12/2024	Added to Annual Cycle of Business, for December agenda.	**Not Yet Due**
84	19/07/2024	BLMK ICS - 2023 System Staff Survey Results	To update the Board on progress on issues arising from the staff survey and in particular in relation to inclusion and diversity	Martha Roberts		27/09/2024	22/8/24: MW - to be included in CEO report for September Board.	**COMPLETE: Propose closure at next meeting (27/9/24)**
85	19/07/2024	Analysis of BLMK Acute Hospitals Emergency Activity	To return to the Board with an update on planning in September	Michael Ramsden		27/09/2024	On agenda for September meeting.	**COMPLETE: Propose closure at next meeting (27/9/24)**

Action No.	Meeting Date	Agenda Item	Action	Action Owner	Past deadlines (Since Revised)	Current Deadline	Current Position (latest update)	RAG
86	19/07/2024	Analysis of BLMK Acute Hospitals Emergency Activity	To incporate engagement and insight with outside organisations such as Age UK and British Heart Foundation into planning	Michael Ramsden		27/09/2024	22/8/24: Age UK and British Heart Foundation have been invited to the Winter Planning Workshop to ensure their engagement and insight is factored into the plans.	**COMPLETE: Propose closure at next meeting (27/9/24)**
87	19/07/2024	Partner Governance Reports	Place Link Directors to discuss Healthwatch and VCSE representation on the Place Boards	Anne Brierley Nicky Poulain Sarah Stanley Maria Wogan		27/09/2024	29/8/24 - Healthwatch and the VCSE are represented on the MK Health and Care Partnership and Luton Place Board. Bedfordshire CVS is a member of the Bedford Place Board. CBC Place Board does not include VCSE and Healthwatch.	**COMPLETE: Propose closure at next meeting (27/9/24)**
88	19/07/2024	Partner Governance Reports - MHLDA	Priorites for the Collaborative to be circulated to members and attendees	Ross Graves		23/07/2024	Circulated to members 22/7/24.	**COMPLETE: Propose closure at next meeting (27/9/24)**
89	19/07/2024	Partner Governance Reports- MHLDA	To develop a broader communication plan in relation to MHLDA Collaborative	Ross Graves		27/09/2024	2/9/24 - Action has been picked up by MHLDA team who are developing a communications plan, being finalised during Q3, and will link with ICB, ELFT and CNWL communications teams to roll this out. Regular updates will be provided to MHLDA Collaborative Committee.	**COMPLETE: Propose closure at next meeting (27/9/24)**
90	19/07/2024	2024/25 Section 75s (Non Better Care Fund)	To consider how the Board can have a broad overview of S75 arrangements	Kathryn Moody		27/09/2024	30/8/24 - It is proposed that a paper comes to the Board in March each year which reviews how arrangements have worked in the previous year and requirements for the following year. This has been added to the Annual Cycle of Business. An update on S75 arrangements will be included in the CEO report at each meeting where applicable.	**COMPLETE: Propose closure at next meeting (27/9/24)**
91	19/07/2024	2024/25 Section 75s (Non Better Care Fund)	To amend 4.4 of the Luton agreement. It states "the integrated equipment (for which funding is provided through the BCF)", but not all integrated equipment is funded through the Better Care Fund.	Kathryn Moody		25/07/2024	30/8/24 - Any amendments to the S75 agreements will be included in future variations which will be presented to the Board for approval.	**COMPLETE: Propose closure at next meeting (27/9/24)**
92	19/07/2024	Communication from the Meeting	Communications from the meeting to be shared with partners.	Michelle Summers			Completed.	**COMPLETE: Propose closure at next meeting (27/9/24)**

Bedfordshire, Luton and Milton Keynes Integrated Care Board
Decision Planner

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

Status	Ref No.	Topic	Decision to be taken	Decision Taker	Scope	Date of Decision	ICB Board Sponsor
FUTURE	10085	ICS Infrastructure	To approve an ICS Infrastructure Strategy.	Board of the ICB	BLMK	27 Sep 2024	Chief Finance Officer
FUTURE	10098	Health Services Strategy	Approval of Health Services Strategy	Board of the ICB	BLMK	27 Sep 2024	Chief Medical Director
FUTURE	10118	Winter Planning	Winter Planning	Board of the ICB	BLMK	27 Sep 2024	Chief Medical Director
FUTURE	10122	IUC procurement	Integrated Urgent Care procurement pathway	Board of the ICB	BLMK	27 Sep 2024	Chief Primary Care Officer
FUTURE	10079	Strategic Data Platform	To agree the approach to procuring a hosted ICS wide strategic data platform	Board of the ICB	BLMK	13 Dec 2024	Chief Medical Director
FUTURE	10102	s75 Agreements	Approval of 2024/25 Section 75s (BCF)	Board of the ICB	BLMK	13 Dec 2024	Chief Operating Officer
FUTure	10114	Primary Care Access Plan	Primary Care Access Plan assurance	Board of the ICB	BLMK	13 Dec 2024	Chief Primary Care Officer
FUTURE	10123	Primary Care	Agree Primary Care Strategy	Board of the ICB	BLMK	13 Dec 2024	Chief Primary Care Officer

Bedfordshire, Luton and Milton Keynes Integrated Care Board
Decision Planner

Status	Ref No.	Topic	Decision to be taken	Decision Taker	Scope	Date of Decision	ICB Board Sponsor
FUTURE	10125	Learning Disability Death reviews	Annual report on reviews of deaths of people with Learning Disabilities	Board of the ICB	BLMK	13 Dec 2024	Chief Nursing Director
FUTURE	10118	Provider Selection Regime - Contracts	Approve the next steps on Community, Mental Health and Children's services contracts	Board of the ICB	BLMK	13 Dec 2024	Chief Operating Officer
FUTURE	10105	Clinical Policy Development/	Agree a Clinical Policy Development process	Board of the ICB	BLMK	21 Mar 2025	Chief Medical Director
FUTURE	10115	Start Well Strategic Priority	Update on Start Well Strategic Priority (presented to Board 19/7)	Board of the ICB	BLMK	21 Mar 2025	Chief Nursing Director
FUTURE	10117	Planning	Approve the Operational and Financial Plan 2024/25 and	Board of the ICB	BLMK	21 Mar 2025	Chief Operating Officer
FUTURE	10119	Planning	Approve revised Joint Forward Plan	Board of the ICB	BLMK	21 Mar 2025	Chief of Strategy & Assurance
FUTURE	10092	Environmental Sustainability	ICS Climate Change Adaptation plan	Board of the ICB	BLMK	1 Jun 2025	Chief of Strategy & Assurance

Bedfordshire, Luton and Milton Keynes Integrated Care Board
Decision Planner

Status	Ref No.	Topic	Decision to be taken	Decision Taker	Scope	Date of Decision	ICB Board Sponsor
FUTURE	10095	Environmental Sustainability	Revised Green plan	Board of the ICB	BLMK	1 Jun 2025	Chief of Strategy & Assurance
FUTURE	10112	Delegation of Public Health 7a services from NHSE	Transfer/delegation of Public Health Section 7a services commencing with the delegated responsibility for the national childhood vaccinations and immunisation programme,	Board of the ICB	BLMK	1 Jun 2025	Chief Primary Care Officer
FUTURE	10113	Place delegation framework	Agree a framework to delegate resources and responsibility to Place	Board of the ICB	BLMK	1 Jun 2025	Chief of Strategy & Assurance

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 27 September 2024

Executive Lead: Felicity Cox, ICB Chief Executive

Report Author: Michelle Evans-Riches, Head of Governance and Stephen Makin, Deputy Chief of Finance

Report to the: Board of the Integrated Care Board in Public

Item: 4 Annual Report and Accounts 2023/24

Reason for report to the Board:
(a) power to approve is reserved to the Board.

1.0 Executive Summary

1.1 The Annual Report and Accounts 2023/24 was approved at an Extra-Ordinary meeting of the Board in private on 26 June 2024. They were duly submitted to NHS England on 28 June 2024. The full Annual Report & Accounts has been published on the ICB's website **here**.

1.2 This year the ICB is also pleased to publish a much shorter summary of the Annual Report and Accounts, more suited to sharing with residents. This is available on the ICB website **here**, and is also attached at Annex A. This summary has been published alongside several short, resident-focussed videos which capture different elements of the system's work in partnership this year. We will be sharing these materials widely with residents and partners following the Board's discussion today.

1.3 The National Health Services Act creates a requirement for ICBs to produce an Annual Report that:

- explains how ICBs have discharged their duties under sections 14Z34 to 14Z45 and 14Z49 (general duties of ICBs)
- reviews the extent to which the board has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)
- reviews the extent to which the board has exercised its functions consistently with NHSE views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and reviews any steps that the board has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007. ICBs must consult each relevant Health and Wellbeing Board

2.0 Recommendation

2.1 The Board is requested to **note** the annual reports and accounts for 2023/24.

3.0 Key Implications

Resourcing	
Equality / Health Inequalities	✓
Engagement	✓
Green Plan Commitments	✓
BAF Risks	✓

3.1 The Annual Report necessarily focusses on the past year and as such does not include any new resource commitments. The Report meets its statutory requirement to comment on how we have sought to reduce inequalities in the reporting period.

3.2 The production of the annual report is a statutory requirement and includes content on how we have discharged our duties in relation to climate change in 2023/24.

4.0 Report

4.1 The Annual Report and Accounts 2023/24 was produced in accordance with NHS England guidance and was approved by at an Extra-Ordinary meeting of the Board in Private on 26 June 2024. It was subsequently submitted to NHS England by the deadline of 28 June 2024.

4.2 The Annual Report and Accounts have been published on the BLMK ICB website here alongside a shorter summary document for sharing with residents, **here**. In 2023/24 BLMK ICB met the statutory financial duties to keep expenditure within the resources available. The Report includes many examples of innovative practice and partnership in action, both at system at Place level. The Board will receive a short presentation of the Annual Report and Accounts from the Chief Executive Officer at the board meeting.

4.3 NHS England undertakes an annual assessment of all ICBs. The BLMK annual assessment took place on 17th July 2024 for the annual year 23-24.

NHSE are required to conduct a performance assessment of each Integrated Care Board (ICB) with respect to each financial year. In making this assessment, they consider evidence from our annual report and accounts; available data; feedback from stakeholders and discussions at the afore mentioned meeting.

The Annual Assessment looks at our organisation's performance against the specific objectives set by NHS England and the Secretary of State for Health and Social Care, our statutory duties as defined in the Health and Care Act 2022 and our wider role within the Integrated Care System across the 2023/24 financial year.

A more detailed update on our ICB's annual assessment for 2023/24 can be found in the Chief Executive's Report.

5.0 Next Steps

5.1 The Board are asked to **note** the annual reports and accounts for 2023/24 and the plans for sharing a summary of the Annual Report with partners and residents across BLMK.

List of appendices

Appendix A – *Summary of BLMK ICB Annual Report and Accounts 2023/24.*

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 27 September 2024

Executive Lead: Felicity Cox, Chief Executive Officer

ICS Partner Lead: N/A

Report Author: Georgie Brown, Chief of Staff

Report to the: Board of the Integrated Care Board in Public

Item: 6 Chief Executive Officer's Report

Reason for report to the Board:
To provide an update on the activities of the Chief Executive Officer and Chair since the last meeting of the Board.

1.0 Executive Summary

1.1 This report provides a summary of corporate activities since the last Board Meeting on 19 July 2024.

2.0 Recommendation

2.1 The members are asked to receive this report for **noting**.

3.0 Key Implications

Resourcing	✓
Equality / Health Inequalities	✓
Engagement	✓
Green Plan Commitments	

3.1 Risks are logged and managed through the specific pieces of work and the corresponding governance.

3.2 There are no financial or workforce implications to this report.

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

4.0 Report

4.1 **Introduction –** When the Board last met, we had just had the results of the general election. We now have a new government, ministerial team and new local MPs. Rima and I have already had the opportunity to meet with several of our new representatives and will continue to do so, to share information about the ICB, its' priorities and to hear what is important to local residents.

The ICB has now been operating for over a year and is starting to build progress across the priority areas. Whilst this has been, and remains, a challenging year in many respects, we also have real opportunities for our services, staff and residents to improve outcomes, increase efficiency and ensure value for money. We are planning a number of reviews across our partnership to ensure we continue to learn from what is working and where we can continue to strengthen our work.

Whilst we await further detail on the new governments plans and priorities for health and care, we will continue to work to deliver our current plan at pace, strengthening and maintaining a firm grip on our priorities and ambition, our services and support to our teams.

4.2 **HSJ Award Nomination – The Denny Review into Health Inequalities**

I am delighted that the Denny Review has been shortlisted for a prestigious national HSJ award. The Review is fundamental to everything we do in BLMK, and the Board I know remains focussed on delivering the Denny recommendations at all levels of the system. We look forward to the formal ceremony later this year, and will, as part of the next stage of the process, be presenting to HSJ judges. This, as with everything we do, will have resident views and experience at its core.

4.3 **ICB Staff Awards Event, 24 September 2024**

The whole ICB is looking forward to the inaugural Staff Awards Event on 24/09. We are delighted to have received over 150 nominations recognising the unique contributions of our staff to improving health and wellbeing in the UK. The event will be held in Flitwick. Long Service Awards will also be presented to staff with over 25 years consecutive service to the NHS at the event.

4.4 **ICB Annual Assessment**

BLMK ICB met with the NHSE Regional team on 17th July 2024, which formed our formal annual assessment of the ICB for 23-24. The assessment of the ICB by the regional team is submitted to the national team for moderation (August/September). Following moderation NHSE will publish a summary of our annual assessment along with our capability rating.

NHSE are required to conduct a performance assessment of each Integrated Care Board (ICB) with respect to each financial year. In making this assessment, they considered evidence from our annual report and accounts; available data; feedback from stakeholders and discussions at the afore mentioned meeting.

The follow up Annual Assessment letter sets out our organisation's performance against the specific objectives set by NHS England and the Secretary of State for Health and Social Care, our statutory duties as defined in the Health and Care Act 2022 and our wider role within the Integrated Care System across the 2023/24 financial year.

Feedback includes where the ICB is displaying good or outstanding practice and where it is felt further progress is required. Consideration has also been given to how we have delivered against the local strategic ambitions as detailed in the JFP and the balance of local and national priorities. The letter is appended to this report.

NHS England were encouraged to see the breadth, and examples of good practice and successful delivery, underpinned by good partnership working; including:

- Development of strong relationships with local authority and other non-NHS partners
- Worked work with system partners to align the Health and Wellbeing strategy and operational plans.
- A robust response to *The Denny Review Report* and proactive commissioning of the Institute of Healthcare Improvement to develop an improvement approach to quality and performance.
- Delivery across a range of operational standards including 76% 4-hour ED.
- Achievement of 23/24 Financial Plan as a System and the approach to system working across the financial community in 2023/24
- The Head of Internal Audit opinion for 23/24 noted substantial assurance for both design and operational effectiveness on key financial systems.
- In line with other ICBs, BLMK have recruited a Chief Midwife

Areas for development**:**

- A need to improve the relationships within the Bedfordshire Care Alliance and between the ICB and Bedfordshire Hospitals NHS Foundation Trust to drive improvements for patients. This requires better working from all sides. It was acknowledged that the Milton Keynes place is functioning relatively well. . **ICB *Action****: We are commissioning an independent review of the Bedfordshire Places and BCA which will support all partners to identify opportunities for improvement (see 4.6).*

- A need for greater joint working across the system to deliver urgent and emergency care transformation and sustained performance and to reduce the impact of delays in urgent and emergency care flow on elective care. ***ICB Action****: We have significantly strengthened our governance and performance management arrangements for UEC performance at system, MK and Bedfordshire footprints, including agreeing key risk indicators. We have agreed transformation priorities for UEC in MK and Bedfordshire which we are developing and delivering with support from place and system transformation teams and oversight via the new governance arrangements. Oversight of elective performance has additional scrutiny at fortnightly meetings with the acute trusts on delivery of our close down key performance indicators. The CDC programme is delivering increased access to diagnostics and we are undertaking system wide work on challenged elective specialties such as gynaecology.*

- A need to more clearly establish and assert the ICBs role in Oversight, Commissioning, Contract and Performance Management at system and at place. ***ICB Action****: The ICB has strengthened its executive governance and oversight of acute, mental health and community sectors. As an executive team the ICB has introduced a monthly performance executive meeting which integrates contract reviews and risk management. (4.5)*

- A need to work more closely with the regional team on matters of safeguarding and quality. We will use multi-disciplinary teams to discuss how to do this together more effectively. . ***ICB Action****: The Chief Nurse has met with region to discuss and provide assurance*

    - A clearer articulation on how the ICB is coordinating population health management programme across the entirety of its population recognising the programmes of work underway at place. ***ICB Action****: a description will be provided of how this is being addressed by the Portfolio report which provides detail on all PHM programmes at population and place level*
- A need to deliver greater levels of productivity across the system to reduce the underlying deficit of the system. Acknowledging the positive steps taken during 2023/24 to deliver a balanced plan there is a need to reduce the reliance on nonrecurrent funding. . ***ICB Action****: The system has a specific focus on productivity at our regular operational and financial delivery meetings for acute, mental health and community sectors. We have engaged some external support for the work on productivity in the ICB and MKUH and BHFT is taking a similar approach, a productivity dashboard is in development to track progress in this area*

- The ICB and Bedfordshire Hospitals NHS Foundation Trust will need to continue working together to ensure that an approach is formulated to improve maternity services while also considering the broader perinatal agenda. . ***ICB Action****: This will be addressed through the Safety Summit on 23rd September.*

In our first full year of operating as an ICB it is positive to see some of the excellent and ongoing work to date. The main areas of development I feel are already understood by us and these and other actions have been collated into an action plan to address the specific recommendations from our annual assessment, as well as continuing to build on our successes.

4.5 **Review of Contracts**

The ICB are undertaking a review of all contracts (clinical and non-clinical) to ensure best value for money and to ensure a proactive and planned timetable of procurement. To support this, a structured review and scoring process through a multidisciplinary approach is being established. It is our intention that no non-clinical contracts will be extended/renewed without first going through this process of review and recommendation.

4.6 **Independent Review of Place and Bedfordshire Care Alliance**

You will recall in December 2023, the Board received an independent review by Carnall Farrar of the MK Deal and place working in MK. This review has helped to shape the direction of work in MK to 2028 and enabled place working to function well. The Local Authority CEOs within the Bedfordshire geography have confirmed that they would like a similar review to be undertaken. As a result, the ICB has planned to commission a review to take place during September. As a key interface for place working in Bedfordshire, the Bedfordshire Care Alliance (BCA) will be included in the scope of the review, which is supported by Bedfordshire Hospitals.

The output from this review will provide actionable advice for the three places, the BCA, and the ICB, and will feed into our wider system governance review that will complete by the end of March. The review will recommend to the Board of the ICB any changes that need to be made to our formal governance arrangements, including to the Bedfordshire Care Alliance Committee, and to ICB delegation arrangements to the BCA and Places.

4.7 **Specialised Commissioning Update**

As previously reported to the Board, the delegation of commissioning responsibilities for 59 specialised services to ICBs commenced on the 1 April 2024, with governance and oversight through the Joint Commissioning Consortium (JCC) and the Regional Specialised Commissioning (SC) function, hosted by BLMK ICB. Key updates since last period:

- **Strategy development:** Work is underway to understand and align priority focus areas, opportunities and agreeing a JCC specialised commissioning vision and five-year strategy. Two stakeholder workshops are planned to co-design and finalise strategy in Nov/Dec 2024.
- **SC staff transfer to BLMK on 1 April 2025**: The transition programme of work is continuing, with BLMK and NHS England HR teams working through the due diligence processes to ensure the smooth transfer of staff, information records, and budget.
- **Expansion to delegated services:** Following confirmation by NHS England in August, a work programme is underway to ensure safe transition of the further 11 specialised services that will be delegated to ICBs from the 1 April 2025.
- **Business as Usual (CQI):** The 2024/25 SC contract agreements are now almost finalised, with monthly reporting and discussions through the JCC subcommittees. The JCC 2024/25 work programme has 15 transformation programmes, and oversight of the clinical network workplans.

Mount Vernon Reprovision

As the Board heard in March, the plan for relocating the Mount Vernon Cancer Centre is a regional priority for the East of England which accounts for the largest share of patients attending the cancer centre. Proposals have been developed jointly with ICBs in the East of England and in London and the South East whose populations the cancer centre also serves. The BLMK ICB Executive have been asked as all ICBs in East of England have agreed the Mount Vernon Cancer Centre review could start the formal assurance process with NHSE, as the next step, before the decision to go ahead to public consultation can be made.

The programme is moving towards next phase of assurance process prior to the launch of consultation. The next steps are to complete the independent assurance process during October and then to seek approval to go to consultation on the MVCC proposals. At the next Joint Commissioning Consortium formal approval will be sought on behalf of East of

England ICBs to move to next stage of assurance. Given the number of commissioning organisations involved in the assurance process (Joint Commissioning Consortium on behalf of BLMK and HWE, London and South East NHSE Regions) the consultation is now expected to launch in December 2024. ICBs will be asked to support to decision to consult following the NHSE assurance process during October. For BLMK we will aim for a paper to Quality and Performance Committee in November 2024 to support the next steps of the assurance phase.

4.8 **Non-Emergency Patient Transport**

Work to develop a new model for Non-Emergency Patient Transport (NEPTS) continues. It remains the ambition of the ICB to redesign the service with existing providers and wider stakeholders within the Voluntary, Community and Social Enterprise (VCSE) sector to support a more sustainable and responsive model. More detailed discussions have taken place with the VCSE regarding what may be possible, although it is recognised that the level of activity required by the ICB will require greater development and resource than is currently in place.

Discussions are also ongoing with existing providers to shape a new service, and a group looking at the development of New Models of Care has been established between the ICB and East of England Ambulance Trust, with South Central Ambulance Trust also feeding into this as the two incumbent providers. This work will take place over the coming months and will look at capacity and demand, more effective ways of organising NEPTS and also understand the resource required, both in terms of staffing and types of vehicle.

4.9 **Members of Parliament**

I have been pleased to meet with several Members of Parliament since their election/re-election in July. These discussions – with Blake Stevenson MP, Alistair Strathern MP, and Richard Fuller MP, are important in hearing constituents' views, asking for Members support with key messages and projects, and discussing local ambitions to improve health services and respond to growing demand. Rima and I have written to all MPs and look forward to meeting remaining Members in the short term.

4.10 **Meeting with the Secretary of State for Health and Social Care, the Rt Hon Wes Streeting**

I was pleased to attend the NHS East of England leaders' engagement session at Harlow College as an opportunity to meet our new Secretary of State for Health and Social Care in person to find out more about his priorities, vision for the NHS and ask questions.

4.11 **Transformational Reciprocal Mentoring Programme**

As part of my latest assignment as part of this programme, I had the pleasure of discussing with a selection of ICB staff on a one to one basis their experiences of organisational culture in relation to race equality and inclusion. I am passionate about growing knowledge to develop and support people from all backgrounds to achieve more at work, through better understanding of how ethnicity and culture affects people's lives and life experience.

4.12 **Events and Meetings**

The Chief Executive Officer and Chair attended the following events and meetings on behalf of the ICB:

12 June	**Introduction Meeting between ICB Chair, Chief Executive Officer and John Tizard, newly appointed Police and Crime Commissioner for Bedfordshire.**
15 June	**NHS East of England ICB and Provider CEOs Event at Duxford.**
16 July	**Quarterly Meeting of the ICB Executive Team and Bedford Borough Council Management Team.** This was a productive meeting focusing on Better Care Fund, estates, development of place and the financial position.
17 July	**ICB Regional Review Meeting with NHS East of England.**
20 July	**Opening Ceremony of Sri Lanka Stand and Afternoon Tea with the Mayor of Bedford.**

	The Chief Executive Officer was pleased to attend events at the Bedford River Festival on Saturday 20 July.
23 July	**ICB Chief Executive Officer introductory call with Steve Shepherd, Helpful Partners, regarding NHS Leadership and Innovation.**
29 July	**Meeting with The Open University.** The Chief Executive Officer, Chief People Officer and Chief Primary Care Officer met with key representatives from the Open University in Milton Keynes to discuss Primary Care, potential students and future workforce requirements.
07 and 15 August	The Chief Executive Officer chaired meetings during August to discuss a number of actions from the Mental Health Summit in June. Actions were discussed in relation to housing issues in Luton and out of area beds. Solutions and next steps were explored to ensure that momentum is maintained in these areas.
19/08/2024	**ICB Corporate Induction.** The Chief Executive Officer was delighted to open the inaugural session to welcome new staff to the ICB.
21 August	**ICB Chief Executive Officer met with Richard Fuller MP.**
22 August	**Introduction Meeting between ICB Chief Executive Officer and Blake Stephenson MP.**
28 August	**ICB Chief Executive Officer met with Alistair Strathern MP.**
03 September	**NHS Leadership Event in London,** attended by the Chief Executive Officer.
05 September	The Chief Executive Officer presented at the CCA Central London
10 Setember	The Chair participated in the recording of a podcast for Voices of Care.
11 September	**Opening of the Sue Ryder Grief Kind Garden.** The Chief Executive Officer attended the opening of the relocated Sue Ryder Chelsea Flower Show Garden. It was an opportunity to meet some of the fantastic hospice team and speak to fellow key stakeholders from across Bedfordshire, Luton and Milton Keynes.
13 September	**Meeting with Professor Oliver Shanley OBE, Regional Chief Nurse, NHS England.** The Chief Executive Officer met with Professor Shanley to discuss reflections and insights in relation to Mental Health Services.
23 September	**Quality and Safety Summit for Bedford Hospital Maternity and Neonatal Services.**

4.13 Since the last Board Meeting, the following publications and guidance relevant to Integrated Care Systems has been published. Key items for the Board to note:

- Virtual Wards Operational Framework: https://www.england.nhs.uk/publication/virtual-wards-operational-framework/
- GP Seasonal Influenza Vaccination Programme Enhance Service: https://www.england.nhs.uk/publication/gp-seasonal-influenza-vaccination-programme-enhanced-service-24-25-additional-guidance/
- Data Protection Impact Assessment for the Federated Data Platform: https://www.england.nhs.uk/publication/overarching-data-protection-impact-assessment-dpia-for-the-federated-data-platform-fdp/
- Federated Data Platform Information Governance Framework: https://www.england.nhs.uk/publication/federated-data-platform-information-governance-framework/
- Framework for Managing the Response to Pandemic Diseases: https://www.england.nhs.uk/publication/framework-for-managing-the-response-to-pandemic-diseases/

5.0 Next Steps

5.1 As described in this report.

List of appendices

Appendix A ICB Annual Assessment Letter

Background reading

None.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 27 September 2024

Executive Lead: Maria Wogan Chief of Strategy and Assurance

Report Author: Dominic Woodward-Lebihan, Deputy Chief of Strategy and Assurance

Report to the: Board of the Integrated Care Board in Public

Item: 7. Our System Strategies and next steps for their development

Reason for report to the Board:
(a) Approving strategy is a power reserved to the Board

1.0 Executive Summary

1.1 Our system currently has 9 system-level strategies. There are a further two due for approval at today's meeting: the Health Services Strategy and the Infrastructure Strategy.

This paper aims to make it easier for the Board to understand the extent to which our strategies come together into a logical whole. It proposes how we should approach strategy development in future to improve Board oversight of impact and delivery.

This paper also updates on work to develop lead indicators or outcome measures for both of our system missions, each of our five Strategic Priorities, and in key areas of transformation.

2.0 Recommendations

2.1 The ICB is recommended to:

- **Agree** the 'Strategic Framework' graphic which sets out how our system strategies align to our five strategic priorities in BLMK (page 4);
- **Note** the proposed measures for both of our system missions, our five Strategic Priorities and for two key transformation programmes (Cancer & CYP) (page 6);
- **Agree** the five principles that will guide future system strategy development in BLMK, and the next steps to improve Board oversight of delivery and impact (page 9); and,
- **Agree** to participate in a short term, focused piece of work with system leaders to develop a clearer Strategy for our ICS Growth Priority (page 9).

3.0 Key Implications

Resourcing	✓
Equality / Health Inequalities	✓
Engagement	✓
Green Plan Commitments	✓
BAF Risks	✓

3.1 **Resourcing** – There are no direct resourcing implications in this paper
3.3 **Health inequalities**–Tackling health inequalities runs through all of the system's strategies.
3.4 **Engagement** – Discussions with residents/partners have informed existing system strategies, many of which have been approved by the Board and its Committees.
3.5 **Green Plan Commitments** – The principles for future strategy development included in this paper set out a greater focus on environmental sustainability in BLMK

There are currently 9 system strategies in BLMK, summarised below:

Strategy	Published?	Agreed by ICB?	Timeframe	Summary	Primary Governance
Population Health Management Strategy	Here	No, approved by BLMK CCG May 2021	2021-2025	• Sets out our PHM vision: to work with our population to optimise health and wellbeing, advance equality in our communities and make the best use of our resources.	None
Primary Care Strategy	No	No, approved by BLMK CCG, May 2021	2021-2023	• Establishes our primary care vision: Across BLMK we aim to deliver improvements in the health and wellbeing of our whole population though a strong, safe and sustainable primary care offer • Presents five pillars: Develop primary care, reduce pressure on emergency hospital services, personalised services provided by integrated neighbourhood working, digitally enabled care & focus on population health. Refreshed Strategy due December 2024 Board.	Primary Care Delivery Group
Data Strategy	Here	No, approved by ICS Partners Board, Sep 21	2021-2025	• Presents four priorities for data: i) Shared Health and Care Record to support direct care, ii) better use of shared data to identify high risk individuals, iii) data to support self care and iv) shared information to support system redesign	Digital Transformation Board
Digital Strategy	Here	Yes, Sep 2022	2022-2025	• Establishes five key themes: i) a resident first approach, ii) digital as an enabler, iii) putting data at the heart of decision making, iv) Personalised Care and v) supporting Collaboration and Innovation.	Digital Transformation Board
Health and Care Strategy (this is our Integrated Care Strategy required by NHS England)	Here	Yes, Jan 2023	2023-2025	• **Overarching system strategy**. Presents our vision: for everyone in our towns, villages and communities to live a longer, healthier life. • Establishes our ambitions (missions): to increase the number of years people spend in good health and to reduce the gap between the healthiest and least healthy in our community • Sets out our five strategic priorities: Start Well, Live Well, Age Well, Growth & Reducing Inequalities, supported by seven 'enablers. • Refreshed System Strategy due before the Board in 2025.	Board of the ICB
People Strategy	Here	Yes, Jan 2023	2023-2028	• Establishes our People vision: BLMK to be an excellent place in which to work, volunteer, learn and live.	People Board

				• Presents six People Strategy workstreams: Primary Care Training Hub, Neighbourhoods, Supply & Retention, Innovation & Education, EDIB & Wellbeing, and Leadership, Talent Management and OD.	
Working with People & Communities Strategy	Here	Yes, July 2024	2024-2027	• Presents our vision: to work with residents & partners to help people live longer, healthier lives – and create a fairer BLMK • Three areas of focus, agreed by ICB in July 2024: i) Learning from Denny, Embedding co-production, and iii) Learning from Insights.	BLMK Insights Network, feeding into ICB Quality Committee
Cancer Strategy	No	No	2019-2024	• Presents the five pillars of our BLMK vision for cancer: i) help available to all, ii) improved care with earlier diagnosis, iii) excellent support during and post treatment, iv) improved ability of patients to access services, and v) great patient experience	Cancer Transformation Board
Learning Disability & Autism Strategy	Here	No	2023-2026	• Establishes five areas of action, with commitments in each (p31/37). These are i) communicate compassionately, ii) offer reasonable adjustments, iii) break down barriers, iv) put people at the centre of their own care & support, and v) keep people well.	Learning Disability & Autism Transformation Board

There are a further two system strategy presented to the ICB Board at today's meeting:

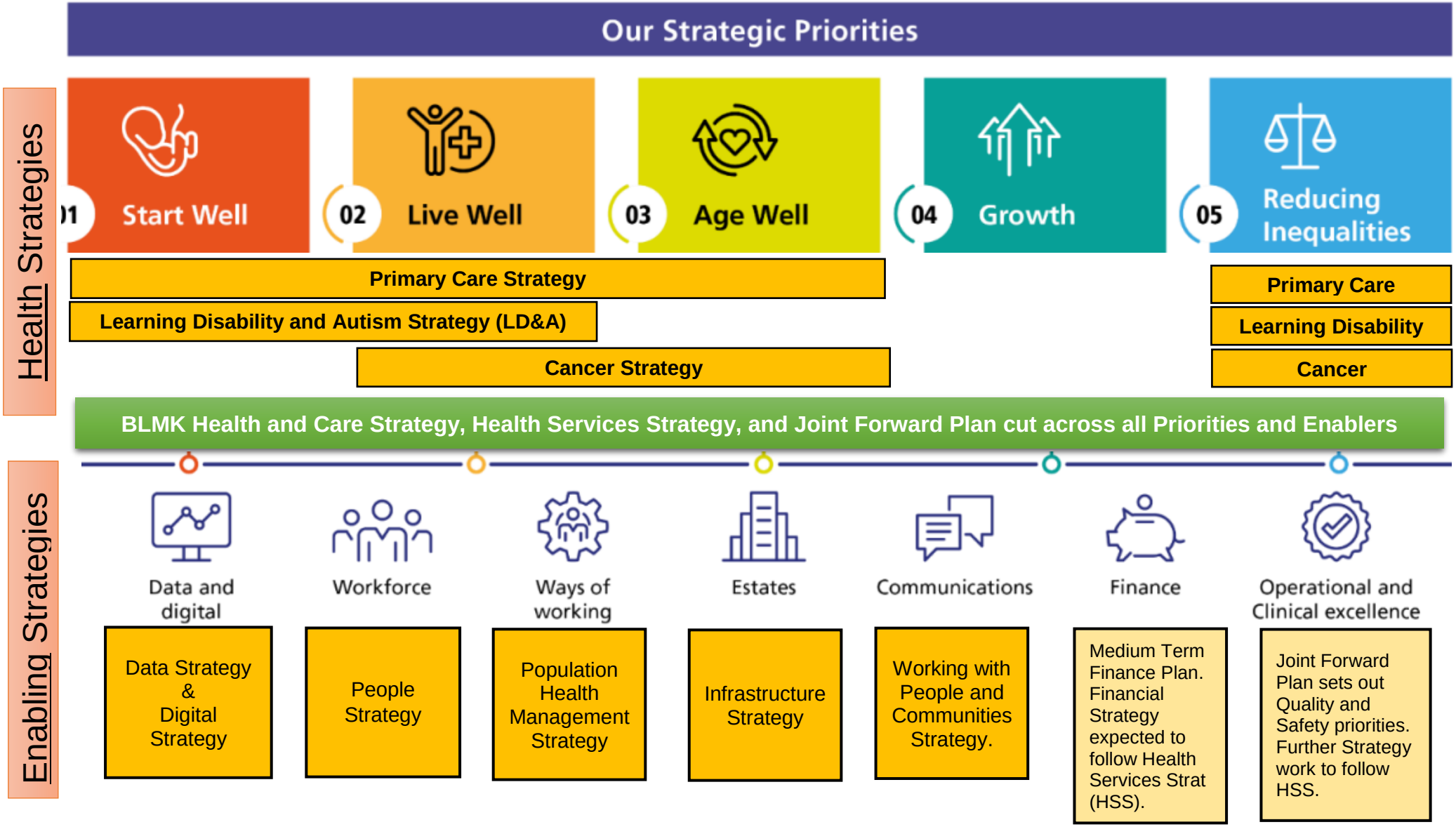
Strategy	Published?	Agreed by ICB	Timeframe of Strategy	Summary
Infrastructure Strategy	As part of Board pack	September 24 (tbc)	2024 – 2034	• Establishes the Strategy is an enabler to our Health Service Strategy • Outlines how we will ensure our infrastructure continues to support us to improve health outcomes, and to protect the sustainability of our services as demand for them grows
Health Services Strategy	As part of Board pack	September 24 (tbc)	2024 – 2040	• Describes how leaders in the provision of health services in BLMK commit to working together over the years ahead: the direction of travel services need to take; the expectations of one another; and the programmes of work which must be undertaken • Presents six priority work programmes: MHDLA collaborative, Children and Families, Cancer, Long Term Conditions, Improving UEC and Fragile Services.

In considering the extent to which these strategies come together to form a logical whole, there are four main challenges:

1. Inconsistent structure in how strategies presented, what they include, and whether published. Some more akin Delivery Plans, others have few actions;
2. The varied timeframes over which strategy is set, sometimes three years, sometimes sixteen, driven in part by national timetables and requirements;
3. The limited rationale for publishing system strategies in some clinical areas, like Cancer, and not in others like Cardiovascular Disease; and,
4. The enduring existence of strategies which were not approved by the ICB, and differences in how visible delivery of each strategy is to the ICB Board.

The next steps for strategy development presented at the end of this paper respond to these issues.

The 'Strategic Framework' below aims to help the Board visualise how our Strategies align to our five Strategic Priorities. Note that it includes only system strategies, and not separate but related system delivery plans, like the Green Plan. Such Plans in most cases are restricted to performance and delivery milestones. We can logically divide our strategies into *Health Strategies* and *Enabling Strategies.*



How our Strategies come together in support of our BLMK Vision and Missions

We have a stated vision in BLMK, established in the 2023 Integrated Health and Care Strategy: for everyone in our towns, villages and communities to live a longer, healthier life. This is underpinned by our two system 'ambitions' or 'missions'. To:

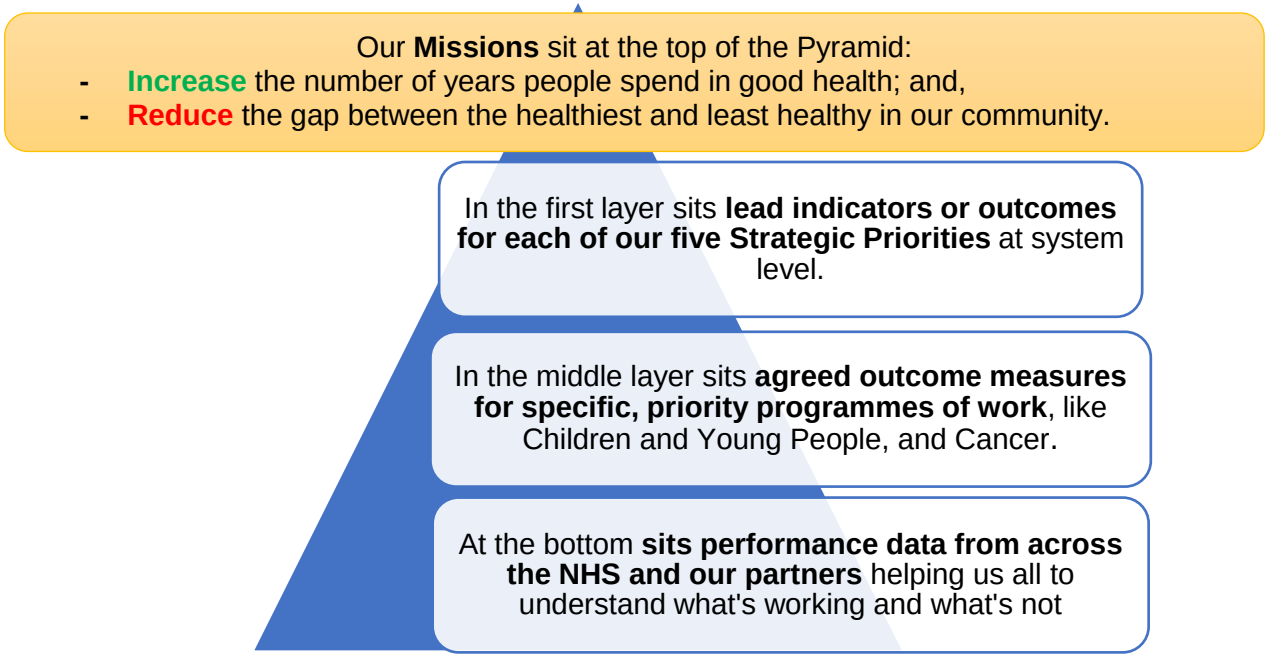
- **Increase** the number of years people spend in good health; and,
- **Reduce** the gap between the healthiest and least healthy in our community.

Each of our strategies contributes to these two missions in a different but important way. This is summarised below.

Strategy	Name	Specific contribution to increasing years in good health & reducing gap between healthiest & least healthy
Health Strategies	Health Services	Central commitments include shifting from healthcare intervention to the prevention of ill health, and to making investment decisions which promote a narrowing in health inequalities. The six priority programmes reflect this.
	Primary Care	Central focus on measures to support primary care resilience and transformation to deliver personalised care for residents at neighbourhood level. 2024 refresh (December Board item) to include greater focus on inequalities.
	LD & Autism	Focus on early detection and intervention and improved access to support via primary care. Measures to support a) reasonable adjustments to screening access and practice, and b) more informed choice, are designed to increase years in good health & reduce gap for adults with severe MH.
	Cancer	Central focus on achieving earlier and faster diagnosis and boosting screening uptake, setting out a range of measures designed reduce later stage diagnosis. Much of this work is targeted in areas of known health inequality where there can be major cultural barriers to accessing early support.
Enabling Strategies	Data Strategy	Focuses on using more shared and integrated data to better identify high risk individuals, and measures to improve data-based decision making in BLMK.
	Digital	Prioritises delivering the Shared Care Record, growing Virtual Wards and driving up NHS usage as ways of improving health in BLMK. Focus on growing digital skills to tackle inequality/exclusion.
	People	Focus on attracting, training, and retaining a sustainable and resilient workforce to deliver services and transformation required. Establishes priority of workforce/leaders reflecting diverse population that we serve.
	PHM	Focus on use of linked data to better enable the system to address variation in outcomes and achieving better understanding of patterns of poor health and wellbeing, identifying groups of residents who are at higher risk and tailoring interventions accordingly.
	Infrastructure	Focuses on how we will use estates and infrastructure to deliver our Health Service Strategy commitments. Commits BLMK to ensuring that prioritisation criteria for capital/revenue investment consider differences in population health need across BLMK.
	People and Communities	Presents mechanisms for building more and better resident insight into decision making, explains how views heard during Denny Review will increasingly shape all we do in BLMK, including growing co-production approaches.

How we measure our progress

Strategies should establish clear priorities. We must be better at measuring whether we are making progress in delivering these, and reporting this to the Board. Accordingly, at the Board's meeting in July, members agreed the BLMK Measurement Framework, the "Data Pyramid", below.



Measuring progress in our Missions

Mission	Headline Measure	Current BLMK Baseline
Increase the number of years people spend in good health;	**Healthy life expectancy at birth**. This is the latest available data	Area **2018/20** / Female / Male Bedford 59.3 62.3 Central Bedfordshire 66.3 67.9 Luton 60.0 59.2 Milton Keynes 65.2 62.1 **England 63.9 63.1**
Reduce the gap between the healthiest and least healthy in our community	**Inequality in life expectancy at birth** (Slope Index of Inequality). This is the latest available data.	**Area 2018/20** / Female / Male Bedford 7.8 8.9 Central Bedfordshire 5.9 5.0 Luton 6.5 8.7 Milton Keynes 7.2 8.4 **England 7.9 9.7**

Data Pyramid Layer 1: Lead indicators or outcomes for each of our five Strategic Priorities[1]

<table>
<tr><th>Priority</th><th>Lead Indicator</th><th>Current Baseline Data in BLMK</th></tr>
<tr><td>Start Well</td><td>Increasing the % of children who reach a Good Level of Development (GLD) at the end of the Early Years Foundation Stage. Children reach GLD if they achieve at least expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of maths and literacy.</td><td>
<table>
<tr><th></th><th>2022/23 %</th></tr>
<tr><td>Bedford Borough</td><td>66.9</td></tr>
<tr><td>Central Bedfordshire</td><td>67.2</td></tr>
<tr><td>Luton</td><td>61.1</td></tr>
<tr><td>Milton Keynes</td><td>69.8</td></tr>
<tr><td>BLMK ICB</td><td>65.5</td></tr>
<tr><td>England</td><td>67.2</td></tr>
</table>
</td></tr>
<tr><td>Live Well</td><td>Reducing preventable premature mortality.
This is defined as per the Public Health Outcomes Framework as death that could potentially be avoided by public health interventions.</td><td>Under 75 mortality rate from causes considered preventable, 2022,
Directly standardised rate per 100,000 population
<table>
<tr><th>Area</th><th>Female</th><th>Male</th></tr>
<tr><td>Bedford</td><td>95.9</td><td>207.8</td></tr>
<tr><td>Central Bedfordshire</td><td>96.5</td><td>168.9</td></tr>
<tr><td>Luton</td><td>130.1</td><td>217.7</td></tr>
<tr><td>Milton Keynes</td><td>120.6</td><td>214.9</td></tr>
<tr><td>England</td><td>108.0</td><td>204.6</td></tr>
</table>
</td></tr>
<tr><td>Age Well</td><td>Reducing emergency admissions for falls.
This is defined as Emergency hospital admissions due to falls in people aged 65+. Preventable risk factors for falls include muscle weakness, visual impairment, polypharmacy and environmental hazards. People with low bone density are more likely to experience a fracture and hospital admission following a fall; these outcomes are associated with loss of independence.</td><td>Emergency hospital admissions due to falls in people aged 65 and over 2022/23. Directly standardised rate per 100,000 population
<table>
<tr><th>Area</th><th>Rate</th></tr>
<tr><td>Bedford</td><td>1,725</td></tr>
<tr><td>Central Bedfordshire</td><td>1,842</td></tr>
<tr><td>Luton</td><td>1,639</td></tr>
<tr><td>Milton Keynes</td><td>1,999</td></tr>
<tr><td>England</td><td>1,933</td></tr>
</table>
</td></tr>
<tr><td>Growth</td><td>Increasing BLMK Employment Rate
This is defined as the number of people in paid work as a proportion of the population</td><td>Employment Rate (2023/24)
<table>
<tr><th></th><th>Apr 23 – Mar 24</th></tr>
<tr><td>Bedford Borough</td><td>82%</td></tr>
<tr><td>Central Bedfordshire</td><td>82.8%</td></tr>
<tr><td>Luton</td><td>68.7%</td></tr>
<tr><td>Milton Keynes</td><td>76.6%</td></tr>
<tr><td>East region</td><td>80.1%</td></tr>
<tr><td>England</td><td>78.6%</td></tr>
</table>
</td></tr>
</table>

[1] The baseline data presented here is subject to validation

Reduce Inequalities	**Average age at time of first long term health condition in BLMK** Gap between the ages at which individuals develop their first long term health condition in those living in most and least deprived quintiles	Inequality in age of developing first LTC, between most and least deprived quintiles. Data accessed 13.09.24.

Area	Gap (years)
Bedford	4.8
Central Bedfordshire	6.1
Luton	2.7
Milton Keynes	4.6
BLMK	4.2

Data Pyramid Layer 2: Outcome measures for specific, priority programmes of work

Here we focus on two example areas, Cancer and Children and Young People. Within the next six months, and pending the views of the Board today, we will continue working with system partners to agree similar headline measures in other key areas, including the six priority programmes outlined in the Health Services Strategy, due to be discussed by the Board today, and in further areas of transformation, like MSK.

Area of Transformation	Top Four Measures	BLMK Baseline
Cancer, *led by the Cancer Programme Board*	- 75% of BLMK cancer patients diagnosed at stage 1 & 2 by 2028 - 85% diagnosed with cancer treated within 62 days of GP referral - Trusts score at/above expected range (8.7) on annual Cancer Patient Exp Survey - 75% of patients surviving cancer 1 year after treatment	- 64.6% (October 2023) - 59.24% (June 2024). - 8.8/10 (Jun 2023). - 73.7% (2020)
Children and Young People, *led by the CYP Transformation Board and LMNS (Local Maternity and Neonatal System). Board.*[2]	- Increasing % of children who reach national average level of General Learning and Development by the end of School Foundation Stage - Reducing Year 6 prevalence of obesity (including severe obesity) - Reducing % of 5-year-olds with experience of visually obvious dental decay - Reducing infant mortality year on year	- (see Start Well, above) - 22.9% (2022/23) - Place level data only - 2.02/1000 (BLMK,23/24)

Another important part of understanding whether the BLMK system is achieving its transformation objectives in key areas is the Portfolio Report, the first version of which the Board welcomed at its meeting in July 2024. An exception report will be provided for December's Board meeting.

Data Pyramid Layer 3: Performance and Improvement Data

The Quality and Performance Report is to be considered at today's ICB Meeting following review by the Quality and Performance Committee on 13 September 2024. The Report is focussed on areas of system concern, and draws links to relevant Transformation and Improvement programmes underway to improve performance (including by linking to the Portfolio Report and the System Risk Register). The Performance Report will increasingly shift to a focus on population health outcomes, in line with the work presented above.

[2] These represent the latest iteration of the work to develop population health focussed strategic outcomes for CYP; some further discussion with partners is required.

Next steps: Delivering better system strategies in BLMK in future:

The planned refresh of around half of our system strategies over the next 18 months, coupled with the planned joint ICB/ICP System Seminars and the launch of the BLMK Insights Network agreed by the Board at its last meeting, present an opportunity for a simpler and more focused approached.

It is proposed that, in future, system strategies presented to the ICB Board should:

1. Begin by stating their contribution to our system's two missions and the intended impact across the full life course[3].
2. Use a consistent format which must not exceed 25 pages. This should include a clear one-page summary which must be written in such a way as to be easily understandable to residents.
3. Explain how the Strategy supports environmental sustainability and economic growth in BLMK;
4. State the population health focussed outcome measures on which success will be measured; and,
5. Be approved by the ICB, with progress reported back on a bi-annual basis, including against the outcome measures presented.

The Board is asked to agree to these five principles. They will then be applied to the refresh of all BLMK strategies in 2025 and beyond.

Next steps for Governance: Improving ICB Board Oversight of System Strategy Development and Delivery

It must be made easier for the Board to monitor the progress and impact of BLMK's System's Strategies. The following next steps are proposed:

1. The ICB should reduce the overall number of System Strategies over the next two years, working towards a single, comprehensive Integrated Health and Care System Strategy. Our evidence-based priorities in the short, medium and long term should be set out here, with clear deliverables – and the precise contributions of each partner – established in our Joint Forward Plan. With the Board's agreement, this approach will guide the required refresh of both our Integrated Health and Care Strategy, and our Joint Forward Plan, in 2025;

2. **For System Strategies due to expire in 2025**, ICB and Partner Leads will be asked to report to the Board i) what the Strategy has achieved, ii) what the consequent shift in population health has been, and iii) whether and how the Strategy will be updated for inclusion in the BLMK Integrated Health and Care System Strategy from 2025 onwards;

3. **For System Strategies not expiring in 2025**, ICB and Partner Leads will come before the ICB Board bi-annually to set out progress/barriers in delivering the Strategy, and specifically progress in meeting the SMART population-health focused outcome measures against which delivery is assessed; and,

4. Though we will retire individual System Strategies where they are no longer required, we will develop new strategy in priority areas where there is none, like our Growth priority. Building on success in some elements of our Anchor programme, most notably on sustainability and workforce, the ICB is keen to bring together senior representatives from our partner organisations in the coming months to outline the strategic direction and priorities for Growth for the ICB. This will then be included in our refreshed Integrated Health and Care System Strategy next year. **ENDS**

[3] Further information about the Life Course Approach can be found here: Health matters: Prevention - a life course approach - GOV.UK (www.gov.uk) This will include articulating the impact in all areas of the Quintuple Aim: Improved Patient Experience, Better Outcomes, Lower Costs, Staff Wellbeing, Health Equity

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 27 September 2024

Executive Lead: Dr Ian Reckless, Chief Medical Officer

Report Author: Dr Ian Reckless, Chief Medical Officer / Catherine Lee, Project Manager

Report to the: Board of the Integrated Care Board in Public

Item: 8. BLMK Health Services Strategy

Reason for report to the Board: Power to approve is reserved to the Board.

1.0 Executive Summary

1.1 In March 2024, the ICB Board confirmed its commitment to the development of the Health Services Strategy to articulate and inform a long-term plan for the development and provision of healthcare services in response to very significant population growth and demographic change. Such a strategy would be essential to drive decision making and inform financial plans going forward. The BLMK Health Services Strategy describes how we - as leaders in the provision of health services in BLMK - commit to working together over the years ahead to ensure our Health Services are sustainable in the long-term.

1.2 The strategy spans the period to 2040. It is therefore high level and designed to be responsive to developments in medical technology, population change and the important work evolving elsewhere across health and care. It is consistent with the health and wellbeing strategies developed in our four constituent Places (Luton, Bedford Borough, Central Bedfordshire, and Milton Keynes), the five Strategic Priorities presented in our Integrated Health and Care Strategy, and our Joint Forward Plan. There have been broad and helpful discussions with a range of health providers informing the evolution of the strategy.

1.3 It is now presented to the Board in final form for approval and agreement to move into the implementation phase which will initially focus on the setting up, reshaping, and resourcing of the six priority work programmes and the Health and Care Professional Leadership Group (which will take on the current functions of the Clinical Senate).

1.4 A verbal update will be provided at the Board to cover substantive feedback received at H&CP and system CEOs on 19 September. It is felt that the proposal to approve (and publish) an appendix to the Strategy early in 2025 will provide an opportunity for the Boards of NHS Providers to receive the strategy, and further influence its implementation.

2.0 Recommendations

2.1 The members are asked to **approve** the Health Services Strategy.

2.2 The members are asked to **approve** the move into the implementation phase of the Health Services Strategy, with an expectation that more specific work programmes (with associated SMART metrics, building upon those presented in the System Strategy paper presented today) are presented back to Board for the six priority workstreams in 6 months' time. Following agreement of those work programmes, it is anticipated that an appendix to the Health Services Strategy will be published.

3.0 Key Implications

Resourcing	✓
Equality / Health Inequalities	✓
Engagement	✓
Green Plan Commitments	✓
BAF Risks	

3.1 **Resourcing:** The goal of the Health Service Strategy is to achieve the best health outcomes possible for the BLMK population ***within*** available resources. It is anticipated that resourcing of the six priority work programmes will largely come from within the existing teams of BLMK partner organisations.

3.2 **Equality / Health Inequalities:** The strategy commits to investment decisions which promote a narrowing in health inequalities and is responsive to the Denny Report in line with other ICB strategy documents.

3.3 **Engagement:** The Health Services Strategy belongs to the organisations providing publicly funded health services within BLMK and has been developed in collaboration with these. The commitments and priority work programmes rely on and set an expectation of a collaborative approach, promoting engagement with each other as well as with the residents we serve across our communities and neighborhoods in BLMK. Through engagement with leaders of these organisations over a period of several months and the strategy has matured by iteration. Key engagement sessions have included (non-exhaustive):

Date	Event	Locality	Sector
17 Apr 24	BHFT / ICB Board to Board Seminar	Bedfordshire	Acute
23 Jul 24	BHFT Executive Group	Bedfordshire	Acute
04 Jul 24	MKUH / ICB Private Board	Milton Keynes	Acute
01 Jul 24	Session with Executive Leads of ELFT and CNWL	BLMK	Community and Mental Health
18 Jul 24	Session with MK Joint Leadership Team	Milton Keynes	Place
23 Jul & 20 Aug 24	BLMK Clinical Leaders and PCN Clinical Directors Meeting (including representatives of Local Medical Committees, LMCs)	BLMK	Primary Care
31 Jul 24	ICB Executive Meeting	BLMK	ICB
19 & 30 Aug 24	Sessions with ICB Non-Executive Members and Primary Medical Services Providers	BLMK	ICB and Primary Care
29 Aug 24	Place Board	Central Bedfordshire	Place
09 Sep 24	Executive Delivery Group (BBC)	Bedford Borough	Place
10 Sep 24	Primary Care Delivery Group	BLMK	Primary Care
10 Sep 24	Place Board	Luton	Place
13 Sep 24	Quality and Performance Committee	BLMK	ICB
17 Sep 24	BLMK Clinical Senate Meeting	BLMK	ICB
19 Sep 24	Health and Care Partnership Meeting	BLMK	ICB

19 Sep 24	BLMK CEO Group Meeting	BLMK	ICB
27 Sep 24	Integrated Care Board Meeting	BLMK	ICB

3.4 **Green Plan Commitments:** The Health Services Strategy is developed alongside and consistent with the Place-based and BLMK Strategies which feed into the Joint Forward Plan. This includes the BLMK Green Plan which will particularly guide the commitment to improving our estate and will be a key part of our role as anchor organisations.

4.0 Report

4.1 This report provides an overview of the purpose, structure, and key areas of focus of the Health Services strategy. The full document is included under appendix A.

4.2 As we look out to 2040, we need to ensure publicly funded health services are sustainable and they achieve the best health outcomes possible for the BLMK population within available resources. This is our mission and motivation behind the Health Services Strategy.

4.3 Nationally, the population is growing and changing in ways which will inevitably affect the requirement of how healthcare is provided. In our system across Bedfordshire, Luton and Milton Keynes, this is particularly apparent and will require us to not just do more but do differently in order to serve and care for our residents.

4.4 The Health Services Strategy sets out a path to meet these challenges through the following:

4.4.1 The **direction of travel** that we believe our services need to take – **"We Will"** statements:

Meeting our future challenges will require a lot of change: the journey must be faced with sufficient maturity that we embrace innovation, evaluate impact, mitigate, and share risk and become tolerant – within reason - of some failures as part of that journey.

The 15 "we will" statements set out in this strategy have been agreed together by the leaders in the provision of health services in BLMK. They are designed to stand the test of time through the scientific, societal, and political changes which are not yet known and will guide the choices we make in our organisations and as partners in our system in the journey ahead.

4.4.2 The **expectations that we have of one another** - **"We Commit"** statements:

The overall impact of the input and efforts of multiple partners is greater than the sum of the parts. If we don't take a strategic approach, we spend our collective energy firefighting rather than actively shaping. The strategy has therefore been developed collaboratively with the organisations and services across BLMK and requires a commitment to continued collaboration in its delivery.

4.4.3 The **priority programmes of work** which we believe must be undertaken as a collective:

1. BLMK Mental Health Learning Disability and Autism (MHLDA) Collaborative
2. BLMK Children and Families *(To incorporate Local Maternity and Neonatal System - LMNS)*
3. BLMK Cancer Board
4. Long Term Conditions – Health Optimisation *(To incorporate the current BLMK Long Term Conditions Programme)*

5. Improving urgent and emergency care (UEC) and reducing unnecessary hospital stays
6. Fragile Services – Access to secondary care, critical mass, peer support and learning *(To incorporate the current BLMK Elective Collaboration Board)*

5.0 Next Steps

5.1 Each of the six priority work programmes will develop SMART goals and a detailed programme of work for the first two years of implementation. This will be reported to the ICB board in 6 months' time.

5.2 On an ongoing basis, the programmes will submit monthly progress reports to **The Health and Care Professional Leadership Group (HCPLG)**.

The HCPLG is a newly formed multi-professional clinical steering group established to monitor and influence the implementation of the Health Services Strategy. The HCPLG will also subsume the current functions of the BLMK Clinical Senate

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List of appendices

Appendix A – BLMK Health Services Strategy, Draft

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Bedfordshire, Luton and Milton Keynes

Health Services Strategy

2024-2040

Contents

Foreword

Why do we need a Health Services Strategy?

The rate at which medical science has continued to advance over the last 15 years is hard to believe: it is estimated that the weight of medical knowledge now doubles every 73 days! We find ourselves in awe at the innovations which transition from 'the laboratory bench to the patient bedside', and which now have a positive impact on people across many parts of the world. These new treatments are being adopted at pace in the National Health Service (NHS), including here in Bedfordshire, Luton, and Milton Keynes (BLMK). Examples include:

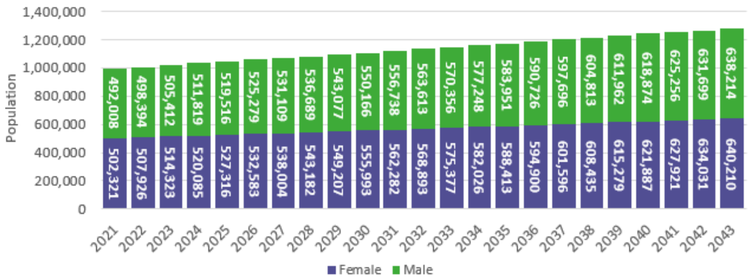
- **Clot-busting medicines** and other interventions used in acute stroke, reducing the long-term burden of significant disability due to cerebrovascular disease.
- Highly **effective vaccines** developed for use within a year of the COVID-19 pandemic.
- A new generation of **surgical robotics**, bringing minimally invasive surgery to more and more patients.
- The use of **genetic tests** to aid the diagnosis and targeted, personalized treatment of a range of conditions.
- New pathways of care for the early diagnosis and treatment of **Alzheimer's dementia**, slowing the loss of independence.
- Modern **insulin therapy** for people with diabetes, including pump and closed-loop hybrid systems, leading to improved quality of life and better long-term outcomes.
- Developments in **organ transplantation**, including living donor transplant, transforming the lives of recipients.
- **New medicines** leading to a revolution in the management of common conditions including heart failure and obesity.
- Technological advances in how we access and deliver our health services – from the **NHS App** and video consultation through to **Virtual Wards**.

These advances, and many others, should be celebrated. They make a real difference to the lives of residents. However, over the same 15 years, not all developments have been so positive:

- Increases in **life expectancy** seen over the first decade of the 21st century have stalled, an effect evident prior to the pandemic and exacerbated by it.
- **Healthy life expectancy** has reduced with both men and women spending more years in poor health.
- Human activity is placing an intolerable strain on our planet, threatening its ecosystems, and creating additional health burdens for populations – healthcare provision both contributes to this **environmental burden** and is impacted by it.
- Advances such as those described above are **costly**, and 'medical inflation' tends to outstrip 'general inflation'.
- Expectations for **economic growth** in the United Kingdom are modest over the medium term with the OECD predicting just 1% growth in 2025.
- The **population** of England and Wales is growing, with the contribution of net migration being greater than that of births and deaths. Notwithstanding, there is a shift in the proportion of the population that is economically active (reducing) and the proportion that is dependent (increasing).
- We have seen a significant decline in most of the **performance indicators** used in the NHS over recent years, exacerbated by the pandemic. Many of the standards contained in the NHS Constitution (Health Act 2009) are not being routinely met across England, including referral to treatment (RTT) and the 4-hour A&E waiting time.
- **Health inequalities** persist – and in some cases widen – with access and outcomes for residents varying according to their economic status and protected characteristics.

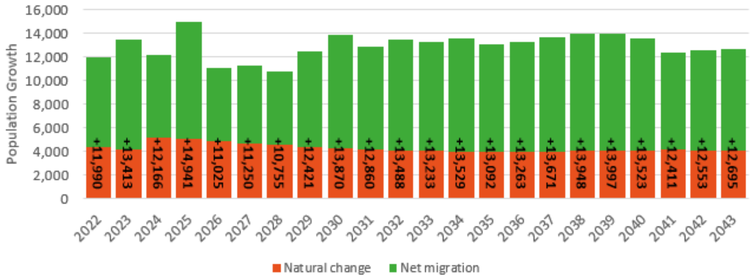
We are not immune from any of these challenges in Bedfordshire, Luton, and Milton Keynes (BLMK). Indeed, Population growth across BLMK has far exceeded – and will continue to exceed – the England and Wales average: the population of England and Wales has increased by approximately 6.3% over the last decade and is projected to continue this trajectory over the next decade. Growth across BLMK has been approximately double the national rate. Over the next 20 years, the BLMK **population is projected to increase by 25%**, primarily driven by housing growth across Bedford, Central Bedfordshire, and Milton Keynes, and through natural demographic growth in Luton.

Figure 1: BLMK Population by Year and Sex



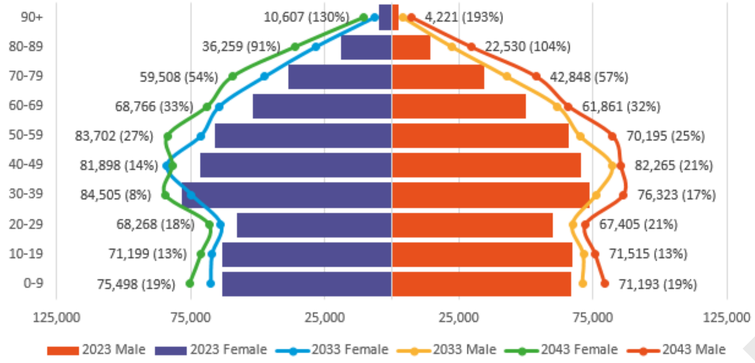
- Across BLMK, international migration will account for 40% of growth, with domestic migration and natural demographic growth accounting for the remainder.

Figure 2: BLMK Population Change from Births, Deaths and Migration



- The age profile of the population in BLMK is changing much more rapidly than the national picture, with significant growth in the population over the age of 50 years. Projected increases in all age bands over 50 years exceed the overall 25% growth projection. The population in BLMK **over the age of 79 years will double** over the next two decades.

Figure 3: Population Pyramid for BLMK in 2023, 2033 and 2043



This leads to an inevitable increase in the incidence of cancer, musculoskeletal and cardiovascular disease. The growth in the elderly population – a subset of whom will experience frailty and dependency – is markedly acute. This is particularly so in our urban centres and is notable in **Milton Keynes** as the 'New City' reaches maturity (and its hospital passes its 40th anniversary): in Milton Keynes, the total population over 77 years of age will double over the twenty years ahead.

- BLMK is not a homogenous geography: as the Denny Review of Health Inequalities makes clear, **significant health inequalities exist** and demand real focus – the populations of Luton and Bedford towns can expect to live significantly fewer years in good health than the England average.

Given these population changes and significant inequalities, health services across BLMK will inevitably need to grow and 'deliver more activity', as they have been doing over the last 15 years. However, the challenge moving forward is of such a scale that **we need not just to 'do more' but to 'do differently'**.

In these challenging times, we must see our role as guardians of health services for future generations, rather than as managers of the status quo. As we look out to 2040, **we need to ensure publicly funded health services are sustainable and they achieve the best health outcomes possible for the BLMK population within available resources**.

The integration of health and care is a key foundation to enable us to **'do differently'** in BLMK. However, the statutory basis of the Health and Care Act 2022 is not in itself sufficient. A range of partners from across BLMK – many of whom are members of our Integrated Care Partnership – need to work ever more closely together, with and in the interests of residents, to establish new models of care. There will need to be an emphasis on joined up working and collaboration, forensic attention to high quality evidence and improvement science, and an intolerance of waste and duplication. Whilst this shift applies to all partners including Local Authorities and social care, it will perhaps be most challenging to achieve for our health services where the purchaser-provider split and the identities of 'sovereign organisations' within our NHS cast a long shadow. **'Doing differently' will not just happen. It will require openness, thought and active planning – it requires a Health Services Strategy.**

The remainder of this document – the BLMK Health Services Strategy – describes how we as leaders in the provision of health services in BLMK commit to working together over the years ahead: the **direction of travel** that we believe our services need to take; the **expectations that we have of one another**; and, the **priority programmes of work** which we believe must be undertaken as a collective (programmes of real significance to our residents, in which 'the whole will be greater than the sum of the parts' through our joint endeavour).

Figure 4: Our Strategies and Plans

The strategy is intentionally high level. It will be responsive to important work evolving elsewhere across health and care. It is consistent with the health and wellbeing strategies developed in our four constituent Places (Luton, Bedford Borough, Central Bedfordshire, and Milton Keynes), and the BLMK Joint Forward Plan.

In particular, the statements, expectations and priority work programmes are structured in such a way to incorporate and deepen our commitment to the **ICB Strategic Priorities**:

Figure 5: BLMK ICB Strategic Priorities

Like the Joint Forward Plan, the Heath Services Strategy spans the period out to 2040. However, with medical knowledge growing exponentially, the strategy is designed to develop by iteration: the direction of travel and the commitments described are expected to stand the test of time, whilst the programmes of work will evolve with science and society. It has been developed in discussion with NHS providers and other key partners in BLMK with whom we share this journey. We commend it to you.

Dr Rima Makarem, Chair, BLMK ICB

Felicity Cox, Chief Executive Officer, BLMK ICB

Dr Ian Reckless, Chief Medical Officer, BLMK, ICB

Sarah Stanley, Chief Nursing Officer, BLMK ICB

Nicky Poulain, Chief Primary Care Officer, BLMK ICB

Dr Tayo Kufeji, Dr Sahadev Swain and Mahesh Shah,
Primary Medical Services Providers Partner Members, BLMK ICB

David Carter, Chief Executive Officer, Bedfordshire Hospitals NHS FT

Joe Harrison, Chief Executive Officer, Milton Keynes University Hospital NHS FT

Claire Murdoch CBE, Chief Executive Officer, Central and North West London NHS FT

Matthew Winn, Chief Executive Offices, Cambridgeshire Community Services NHS Trust

Lorraine Sunduza OBE, Chief Executive Officer, East London FT

Our direction of travel

The challenges facing our health services going forward are stark. To meet these challenges, we will require not 'more of the same' but fundamental changes in the way we work, within and across organisations. Emerging thinking describes a new framework for the provision of health and care, refreshed pathways based on population need rather than traditional distinctions between primary, secondary and tertiary care: an emphasis on digital enablement to support self-care, prevention and access; appropriate and timely access to acute care as and when needed; and, focused efforts through integrated community teams in the management and support of people with complex health issues and those nearing the end of life.

Individuals and organisations have different appetites for the adoption of innovation and change more broadly. We should retain a healthy skepticism about 'change for change's sake' yet remember that whilst '**not all change is an improvement, all improvement is change'**.

Meeting our future challenges will require a lot of change: the journey must be faced with sufficient maturity that we embrace innovation, evaluate impact, mitigate, and share risk and become tolerant – within reason – of some failures as part of that journey.

The statements which follow will guide us on the journey ahead and at the forks in the road which we shall doubtless encounter. We believe that each statement should persist through the scientific, societal, and political changes which are not yet known. Each begins with **"We will"**. This is intentional. We as **leaders in the provision of health services in BLMK**, have together agreed these statements will guide the choices we make in our organisations and as partners in our system.

"We will" Statements

1. **We will** make decisions which support a shift from healthcare intervention to the prevention of ill health.
2. **We will** encourage and enable residents to take an active role in managing their own health and wellbeing and to contribute to the development of healthcare provision.
3. **We will** provide care as close to the resident's home as possible and design services that are 'seamless' for patients and carers.
4. **We will** embrace technology in the design and delivery of health services.
5. **We will** protect access to planned healthcare including operations and procedures.
6. **We will** make investment decisions which promote a narrowing in health inequalities.
7. **We will** ensure that the shape and size of our workforce meet the needs of BLMK's population and support our people to make best use of their individual skillsets.
8. **We will** ensure that value (financial and social) is key to all decision-making.
9. **We will** act to promote parity of esteem between physical and mental health.
10. **We will** work to deliver healthcare in an estate which is fit for purpose.
11. **We will** embrace measurement and a culture of continuous improvement.
12. **We will** achieve excellent outcomes in maternity services and reduce neonatal harm.
13. **We will** prioritise the health of children and young people, including those who are carers.
14. **We will** cultivate a healthy research landscape – improving access to portfolio studies and providing a fertile environment for collaborative local research.
15. **We will** own our roles as anchor organisations within the communities we serve and work to enhance social value.

STATEMENT 1:

We will make decisions which support a shift from healthcare intervention to the prevention of ill health.

At some point in our lives, we will all experience ill health. Many of us will experience chronic illness in the form of a 'long term condition'. When that happens, people should receive support that meets their specific needs and helps them to continue to live a life which is as healthy and fulfilling as possible. Our interventions must be empowering rather than paternalistic. This is directly linked to one of our system's core aims: increasing the healthy life expectancy of our population.

Much of the ill health that we experience is preventable. Our current systems are – to a large extent – set up to manage illness when it presents, rather than to prevent that illness. Preventing avoidable illness through initiatives such as: health education; supporting self-management; smoking cessation; supporting people to stay in good employment; encouraging physical activity and healthy diet; and, maximising the uptake of screening and vaccination will over time lead to less illness – or in a BLMK context, reduce the rate at which the prevalence of ill health increases given our population growth and demographic changes. Proactive interventions and health promotion – particularly through an inequalities lens – will require our primary, secondary and community healthcare teams to support patients in new ways.

The ICB already has co-developed a Primary Care Prevention Plan and this Health Services Strategy provides an opportunity to expand this emphasis on prevention into and beyond secondary care and community services. We recognise of course that poverty, housing, and education are the most significant drivers of ill health and therefore key vehicles for prevention. As a group of anchor institutions, recognising the wide influence of health services, we will work with partners to influence 'wider determinants' through the integrated neighbourhood plans being led at place – the building blocks for good health.

STATEMENT 2:

We will encourage and enable residents to take an active role in managing their own health and wellbeing and to contribute to the development of healthcare provision.

Agency and self-empowerment are key to health and wellbeing, and foundations for effective and appropriate use of health services. We will ensure that people have more choice and control over the way in which their care is planned and delivered, based on 'what matters to them' and their individual strengths, needs and preferences. Services and interactions will be personalised where possible and appropriate.

We will work with (and not 'do to') residents in designing and delivering services, embedding co-production and supporting our communities to thrive. BLMK has published an updated Working with People and Communities Strategy which underpins this work, alongside our system's two Memoranda of Understanding with our **Healthwatch** and **Voluntary Sector** partners.

STATEMENT 3:

We will provide care as close to the resident's home as possible and design services that are 'seamless' for patients and carers.

We recognise that in some areas, health services can deliver better outcomes when delivered at scale with a critical mass of resources and expertise. In BLMK, we are fortunate to be close to several international centres of excellence to which our residents can have access. We will maintain and develop these partnerships. However, for many residents, receiving care as close to home as possible is a priority. All too often, patients travel to receive care rather than care coming to them with services being configured as they are for historical reasons, or for the convenience of the care provider.

We will work to ensure care currently delivered to our residents from outside of BLMK is provided locally in association with our **Integrated Care System (ICS)** partners unless there are very persuasive quality or economic barriers. Where appropriate we will ensure care is provided in the community rather than in our acute hospitals, and on an outpatient basis rather than through admission to a hospital bed where possible.

In doing this, the experience of patients will improve, and we can reduce the risks of deconditioning and additional healthcare-associated illnesses.

For people who do fall ill, the traditional structure and processes of the NHS have created services that can be inequitable and confusing. We will reduce complexity and duplication in order to deliver more joined-up care, with the patient less aware – or even unaware – of organisational boundaries.

Going forward, **integrated neighbourhood working** is a key foundation for our delivery. We will continue to support our place partnerships to build healthier communities through community-led approaches to health and wellbeing. Active involvement of integrated working as guided by Achieving integrated care through community and neighbourhood working – A High Impact Change Model is critical in setting out a future vision for primary care services being active partners in neighbourhood working.

STATEMENT 4:

We will embrace technology in the design and delivery of health services.

We are all aware of the huge advances driven by technology, particularly over the last 20 years. Most of us carry smartphones in our pockets with technical capability dwarfing the desktop personal computers of just a decade ago. As private consumers, we access information and services and make major choices about our lives from a device in our palm. Whilst there is advanced technology embedded in all parts of the NHS, it is not often known for good accessibility and intuitive user interface.

BLMK has been a testing platform for technological innovations – a new generation of surgical robotics, digital dictation, telemedicine, remote consultations, comprehensive electronic health records (allowing 'paper light' working), live linkage between freestanding record systems, cloud-based telephony in Primary Care, patient portals providing personal access to records and a platform for service interaction.

However, there remains unwarranted variation across our system, and many opportunities to 'go further faster', including in our use of the **NHS App**. We will prioritise digital enablement within our health services – for the empowerment of residents, for ease of access to services and in the delivery of those services themselves.

The BLMK Digital Strategy was developed in 2022 and sets out a wide-ranging programme of work, whilst remaining mindful of the potential of digital to impact healthcare inequalities for better or worse.

STATEMENT 5:

We will protect access to planned healthcare including operations and procedures.

In the summer of 2024, over 150,000 people were on waiting lists for planned care with acute providers in BLMK. Of these, 45% have been waiting for over 18 weeks to receive their first definitive treatment with 10,000 people waiting for over a year.

Whilst long waits are found across the NHS and there are a multitude of contributing factors (including the pandemic, industrial action, current and historical funding constraints, rapid population growth, and increases in healthcare demand), it is not a satisfactory state of affairs. Secondary care services are failing to meet the needs or the reasonable expectations of residents and primary care is stretched to capacity holding the care needs of those awaiting the definitive specialist intervention that they require.

We are working hard with partners to recover from this poor position and to eradicate waiting times beyond thresholds set by NHS England, understanding how difficult it is for patients and their families to be waiting for the care they need. In the context of our population growth and demographic change, we should be under no illusion about the scale of the challenge in returning to acceptable and constitutional standards for waiting times, particularly for admitted care.

Going forward, we will find ways in which to prioritise and protect elective capacity whilst maximising the efficiency of our available physical estate (including operating theatres and procedure rooms for diagnostics and intervention). BLMK is one of only two systems in England without a dedicated 'elective care hub'. Whilst such hubs are no panacea, we will develop and progress plans to provide a dedicated and ringfenced footprint for elective care. We will also develop existing and new community diagnostic centres to increase diagnostic capacity, reduce waits and provide services closer to home. This will include work on progressing a community diagnostic centre for Luton.

STATEMENT 6:
We will make investment decisions which promote a narrowing in health inequalities.

Significant differences exist in health outcomes across society. The differential impact of the pandemic on our communities offers a stark reminder of the advantages that some enjoy but others do not.

Here in BLMK, there are relatively modest differences in life expectancy for boys and girls born in each part of the ICS. However, **healthy life expectancy** varies across our four constituent Places (local authority areas). Women in Bedford and Luton can expect significantly fewer years of healthy life than the England average, whilst women in Milton Keynes and Central Bedfordshire can expect significantly more. Men in Central Bedfordshire can expect 8.7 more years of healthy life than their peers in Luton.

There is a strong association between these differences in outcome and socio-economic status. Around 122,000 BLMK residents live in areas amongst the 20% most deprived nationally. Other factors, including ethnicity, contribute towards the variation in outcome.

Whilst some outcome inequalities are driven by rates of disease which may in turn be influenced by genetic factors or risk factors associated with the environment, others may result from difficulties residents face in accessing preventative, diagnostic and treatment services.

The roles of poverty, housing and educational attainment are significant, and with only a limited set of levers available within the NHS to influence. However, by working together in our ICS, we commit to doing ever more to tackle these drivers of inequalities. Fundamental to this is developing our services with our disadvantaged populations such that inequalities are narrowed rather than widened.

BLMK is leading a significant programme of work in response to the publication of The Denny Review in late 2023: we are committed to following through on this work with meaningful actions over the long term. Our partnership with the **Institute for Healthcare Improvement (IHI)** is supporting us to learn from national and international best practice. Our improvement work and investment decisions will take account of the **'CORE20PLUS5'** approach advocated by NHS England. This approach focuses actions on **'5'** clinical areas in populations which sit within the **'20%'** most deprived in England and supports the local identification of other population groups who are outliers for access or outcomes – **'PLUS'**.

STATEMENT 7:
We will ensure that the shape and size of our workforce meet the needs of BLMK's population and support our people to make best use of their individual skillsets.

The NHS is amongst the largest employers in BLMK. In meeting the health challenges on the horizon, we must make the best use of all the expertise and skills available to us and foster a culture of integrated and collaborative working across health and care.

The NHS Workforce Plan articulates current concerns about staff shortages in the NHS which affect its ability to deliver timely and high-quality care and looks to increase the number of staff available for health services each year over the next decade. It does not however tell us how this can best be done.

We will develop systems and services that support a healthy, happy, and productive workforce, making BLMK a place of choice for health service staff. We know that highly trained healthcare staff are in short supply, and this will be exacerbated as the proportion of our population in work is set to fall with the demographic changes projected. It is imperative that highly trained staff spend more of their time doing things that only they can do, operating 'at the top of their licences', and making best use of their hard earnt and scarce specialist skills.

The BLMK Workforce Strategy looks to adapt and enact the national NHS Workforce plan for our population and its future needs. This work is also supported by the **Primary Care Strategy**[1] and we will continue to champion the work of our leading Primary Care Training Hub as an important part of this work.

1. Update to be published Autumn 2024.

STATEMENT 8:
We will ensure that value (financial and social) is key to decision-making.

The resources available for health services are not unlimited and additional resources are frequently sought. However, we recognise that we are already responsible for significant public expenditure each year and we have to ensure these public funds are spent wisely. We must be mindful of the evidence base for expenditure (in terms of improved health outcomes) and intolerant of duplication and waste.

The Joint Forward Plan describes how the ICB medium-term financial planning model and associated financial principles inform how our organisations will work together to ensure resources are allocated fairly, with accountability and for the good of residents. These principles and an unremitting emphasis on value (financial and social) must be core to all of those working within

STATEMENT 9:
We will act to promote parity of esteem between physical and mental health.

The impact of poor mental health pervades our society. People with mental illness experience inferior physical health outcomes and are less likely to fulfil their life goals and economic potential. **Adults living with a 'severe mental illness' die 15-20 years earlier** than their peers from a range of conditions including cancer, cardiovascular, respiratory, and liver disease. The impact of the Covid pandemic on the mental health of children and young people has been particularly marked – at a national level, there are over three times as many children and young people in contact with mental health services than there were seven years ago.

Every part of society has a role to play in supporting positive mental health and wellbeing and in reducing associated stigma. We will agree a common approach to care across our services that places equal value on peoples' mental and physical wellbeing. Our work in this area is driven through the **BLMK Mental Health, Learning Disability and Autism Collaborative.**

STATEMENT 10:
We will work to deliver healthcare in an estate which is fit for purpose.

The physical estate from which we provide health services in BLMK is very variable. We face challenges in providing more space for services as demand grows, whilst also ensuring existing premises are replaced or renewed. The variation, and in some places the inadequacy of existing facilities, is perhaps most evident in primary care where we are supporting the development of integrated neighbourhood teams.

We will do all we can to attract capital investment into BLMK and ensure our use of available funds supports the delivery of services across each of our Places. Our collective plans for investment and development will be shared and coherent. We will continue to value and exploit the benefits of a shared public estate wherever possible, and to work collaboratively to ensure that section 106[2] funding and the Community Infrastructure Levy associated with new housing is put to best use.

We will ensure that the choices we make around the health services estate and service delivery favour low-carbon models that are suitably adapted to our changing climate. BLMK has an ambitious Infrastructure Strategy and sustainable estate is one of the elements of the ICS Green Plan.

2. Ministry of Housing, Communities and Local Government. Available at: publishing.service.gov.uk (accessed July 2024).

STATEMENT 11:
We will embrace measurement and a culture of continuous improvement.

Maintaining and improving the quality of service provision requires focus and commitment: it does not just happen. We will ensure **measurement and evaluation** are core to the commissioning, delivery and decommissioning of health services in BLMK. The pace of change required now is such that there must be a higher tolerance for experimentation and failure: the risks of such failure must be mitigated by forensic attention to data and a readiness to change.

Improvement science is a growing field but open-mindedness, measurement, and transparency – aligned to cycles of Plan, Do, Study, Act (PDSA) – are foundations for most methodologies. We will embrace the work of NHS Impact[3] in our system and make full use of our growing partnership with the IHI. The work of the **System Transformation Team (STT)** will be driven in large part by actively chosen priorities, including those articulated within this strategy. This work will be guided by our system's **quintuple aim[4]** – the advancement of health equity.

3. NHS Impact: www.england.nhs.uk/nhsimpact. 4. The Quintuple Aim for Health Care Improvement: Institute for Healthcare Improvement (ihi.org).

STATEMENT 12:

We will achieve excellent outcomes in maternity services and reduce neonatal harm.

Poor outcomes in maternity services can be devastating for families and are associated with long term socio-economic and health care costs. There are also known to be significant health inequalities in relation to maternity outcomes – Maternal and perinatal mortality reports show worse outcomes for those from Black, Asian, and Mixed ethnic groups and those living in the most deprived areas.[5]

We will apply improvement science and peer support in optimising our maternity and neonatal pathways. **BLMK's Local Maternity and Neonatal System (LMNS)** leads this work.

5. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK). Available at: MBRRACE-UK (accessed July 2024).

STATEMENT 13:

We will prioritise the health of children and young people, including those who are carers.

Life chances are often shaped prior to birth and reinforced in the early years. This truth is a key driver of inequities in health outcomes which persist throughout life. Providing high quality health services for children and young people presents challenges, notably in relation to the highly skilled workforce required.

We will look to maximise the potential of collaboration and joint planning across our system to ensure that services concerned with child development, learning disability, and physical and mental child health become and remain sustainable. We will fully support the delivery of the Early Years Strategies that exist in each of our four Places (Luton Education Strategy, Bedford Borough Early Years Strategy, Central Bedfordshire Council Early Help, Central Bedfordshire Council Education & All age Skills, Milton Keynes Early Help Strategy).

STATEMENT 14:

We will cultivate a healthy research landscape – improving access to portfolio studies and providing a fertile environment for collaborative local research.

An environment which contributes to the development of new knowledge through research is one which will value education, professional development and putting evidence into practice.

Research covers a broad spectrum: from multi-centre randomised controlled trials of a specific intervention through to pragmatic qualitative evaluation of practice, opinion, clinician behaviour or patient experience. Many frustrations evident in healthcare are not borne of a lack of knowledge, but rather barriers to implementing evidence, knowledge, and innovations in everyday practice. These various types of research each have value.

BLMK has unique opportunities. Located in the 'golden triangle' between the academic centres of Oxford, Cambridge, and London, we are home to several universities with distinct character and expertise.

Despite this, our great resource is largely untapped – the large and diverse population which is open to involvement in health service research.

Going forward, we will maximise the access of our patients to the National Institute for Health and Care Research (NIHR) portfolio studies, actively seek to develop and host studies examining wider pathways across health and social care and develop local capability to attract grant funding and deliver high quality home-grown research. Our approach will be driven by the strategy being developed by the **BLMK Research and Innovation Network**.

STATEMENT 15

We will own our roles as anchor organisations within the communities we serve and work to enhance social value.

Studies have shown that **80% of health outcomes are determined by non-health related inputs**, such as education, employment, income, housing, and access to green space.[6] With the introduction of the ICS structure in England, and the ambition for these new health systems to contribute to social and economic development, the role of the NHS as a collection of key anchor institutions has never been more important.

Acting as anchor institutions across BLMK, we can have a positive impact on our communities in the local economy and the environment which in turn have the potential to improve the health of individuals and communities. Some of the ways we can deliver our roles as anchor organisations include:

- **Employment (widening access to quality work):** Being an inclusive employer, paying the real living wage, creating opportunities for local communities to develop skills and access jobs in health and car
- **Procurement (purchasing for social benefit):** Purchasing supplies and services from organisations that embed social value to make positive environmental, social, and economic impacts
- **Housing, Estates and Land use (using buildings and spaces to support communities):** Widening access to community spaces, working with partners to support high-quality, affordable housing, and supporting the local economy and regeneration
- **Sustainability (reducing our environmental impact):** Taking action to reduce carbon emissions and consumption, reduce waste and protect and enhance the natural environment. In this, we will continue to build on the ambitions of the ICS Green Plan
- **Skills and Development (working closely with communities and local partners):** Collaborating with communities to help address local priorities, build on their energy and skills; and work with other anchors and partners to increase and scale impact.

6. NHS England Guidance. Available at: NHS England » Anchors and social value (accessed July 2024).

Expectations we have of one another

Our Commitments

We have set out the scale of the challenge facing health services in meeting the needs of residents over the years ahead, and we have presented the 15 statements above which describe the direction of travel and will act to guide us on the journey ahead.

However, this journey does not simply require a map and a compass; it requires us to all to have a common understanding of the desired destination and (both ourselves and our peers) to actually get there. In meeting the challenges within our integrated care system, we will be **only as strong as our weakest link**. The change that is envisaged cannot be limited to primary care and community services, with the commissioner and acute providers looking on passively. Likewise, if the commissioner and acute providers move forward together without mental health services and social care alongside, progress will be very limited.

We – and our residents – are **'in it together'** which in practice represents a major paradigm shift for the providers of health services. For some decades, health services have been composed of individual business (in the case of primary care) and sovereign organisations aiming to generate a financial surplus (in the case of acute providers) whilst engaged in the provision of high-quality healthcare. There was a 'commissioner-provider split', competition felt real and, at times, collaboration and working together were concepts which could be perceived as counter-cultural.

Relationships across BLMK have matured significantly since the geography was first described as a **Sustainability and Transformation Plan (STP)** in 2016. Partners across the system, and within the Places, know each other and there is more openness than in times past. The pandemic showed us all in a very real way how each part of the system had its strengths and contribution to make.

BLMK's Integrated Care Partnership (ICP) includes a diverse range of NHS organisations, four local authorities, wider public sector partners, multiple voluntary and community sector organisations and our Healthwatch partners. The Health and Care Act 2022[7], which established the integrated care systems, enshrined a duty to collaborate. Looking to the years ahead, it is timely to remind ourselves of what collaboration needs to mean in practice – behaviours we must commit to as individuals and organisations.

The ICP has previously articulated **shared 'principles and values'** and these are pertinent as we agree and then implement this Health Services Strategy:

- Co-production
- Learning and adapting
- Honesty and transparency
- Supportive
- Trusted relationships
- Person and community focused
- Integrity.

As is often the case with principles and values, they are expressed at a high level and are hard to disagree with. In the context of the Health Services Strategy, we must consider what they might mean in practice for the ICB and the many organisations which deliver publicly funded health services for the residents of BLMK.

With these statements, we ask ourselves **'What specific commitments do we need to make to each other?'**

7. Health and Care Act 2022: www.legislation.gov.uk/ukpga/2022/31/contents.

"We Commit" Statements

1. **We commit** to supporting and being respectful of one another, we will engage in peer review and act as critical friends.
2. **We commit** to always acting in the best interests of the population we serve recognising this may mean resources are invested elsewhere in the system.
3. **We commit** to being open and transparent in our dealings with one another, including with respect to data and financial information.
4. **We commit** to making decisions together and explicitly sharing risks associated with the actions we take.
5. **We commit** to calling out waste and duplication, and to being intolerant of silo working, even if this is not advantageous to our own organisations in the short term.
6. **We commit** to not act unilaterally. Where our decisions are likely to have an impact on our partners, we will engage them in the appraisal of options.
7. **We commit** to providing our staff with the skills to work collaboratively, and to leading by example within our organisations.
8. **We commit** to working together to bring additional resources into BLMK for the benefit of our residents.

Priority Work Programmes and Initial Workplans

With the statements and commitments outlined above, we can begin to consider how we might operationalise the strategy as we look to achieve our mission for 2040 – **ensuring that publicly funded health services are sustainable and that they achieve the best health outcomes possible for the BLMK population within available resources.**

We have been developing the strategy in the context of both the work that has already taken place in BLMK and that which may be taking shape now (for example, innovative models of care). We have reviewed the organisation and Place-based strategies, and the Denny review, and consider that the content of the Health Services Strategy is consistent and supportive. Where there is overlap, we see that as a positive thing.

Through the collaborative work already started across BLMK, we have several established 'vehicles' for implementing our strategy and delivering our mission, including:

- BLMK Mental Health Learning Disability and Autism Collaborative
- BLMK Local Maternity and Neonatal System
- BLMK Elective Collaboration Board
- BLMK Long Term Conditions Programme
- BLMK Cancer Board.

These vehicles will either continue in their current form and develop their important work or they will evolve. Overall, there will be **six priority work programmes** for the implementation of the health services strategy.

The extant BLMK Clinical Senate will develop into a **Health and Care Professional Leadership Group (HCPLG),** established as a multi-professional clinical steering group to monitor, and influence the implementation of the Health Services Strategy going forward. The HCPLG will receive progress reports from each of the priority work programmes. As well as subsuming the current functions of the BLMK Clinical Senate, the HCPLG will act as a consultative forum on key issues and decisions being considered by the ICB going forward.

The six priority work programmes, including three new programmes, which will together act as delivery vehicles for the Health Services Strategy are described below, along with the rationale for their creation. The work programmes are deliberately high level – the work upon which they focus will iterate and develop over the years as issues are dealt with and new challenges emerge. The areas of focus for the first two years of the priority work programmes are articulated in more detail and will be soon translate into **SMART** (**S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**ime-bound) goals and objectives.

The use of data (population health and other) will be absolutely core to the six work programmes. We know a lot about the health and needs of our population and have been working alongside our Public Health colleagues in developing the strategy. Whilst the detail of this information is not explored in the strategy document, it must and will guide the work programmes of the delivery vehicles.

Table 1: Six Priority Work Programmes

		Priority Work Programmes	Led by
	1	BLMK Mental Health Learning Disability and Autism (MHLDA) Collaborative	As presently
	2	BLMK Children and Families (To incorporate Local Maternity and Neonatal System – LMNS)	As presently
	3	BLMK Cancer Board	As presently
NEW	4	Long Term Conditions – Health Optimisation (To incorporate the current BLMK Long Term Conditions Programme)	ICB and Primary Care
NEW	5	Improving urgent and emergency care (UEC) and reducing unnecessary hospital stays	Local Authorities, Acute and Community Providers
NEW	6	Fragile Services – Access to secondary care, critical mass, peer support and learning (To incorporate the current BLMK Elective Collaboration Board)	Acute Providers

1 The BLMK Mental Health Learning Disability and Autism (MHLDA) Collaborative

BLMK has amongst the **highest levels of mental health need in the region**, with significant growth (in both demand and acuity) in the aftermath of the pandemic. In 2022/23, there were:

Around **8,000** adults registered in primary care with a serious mental illness (5% growth since 2019/20)

Around **6,500** adults with dementia (↑19% since 2018/19)

Around **90,000** adults with depression and/or anxiety (↑33% since 2018/19)

Around **12,000** referrals to child and adolescent mental health services (CAMHS) in 2021/22 (↑200% since 2018/19)

The NHS spends approximately £224m on specifically commissioned mental health, learning disability & autism services in BLMK. Our Mental Health Investment spend stands at £176 per head of weighted population, which is just below the England average.

BLMK has made considerable progress delivering the NHS Long Term Plan for Mental Health whilst tackling quality and financial pressures. We have:

- Opened **new services** including Evergreen (BLMK-wide inpatient ward for children and young people); additional mental health teams in schools; additional crisis cafes; and the East of England Gambling Service
- Begun an ambitious programme of **transformation of community mental health services**, building community teams around neighbourhoods and working in a more integrated way with GPs, voluntary, and social care
- **Begun to expanded and diversified our workforce**, including new roles such as peer support workers, mental health pharmacists, education mental health practitioners, clinical associate in psychology, and community connectors
- Worked with local authorities to develop **prevention initiatives** (through the prevention concordat for better mental health[8]), and a suicide reduction partnership and plan.

Despite progress, improvement in focus and investment over recent years, multiple challenges and opportunities remain. People are staying for longer in hospital and we have seen an increase in out of area placements. There are also opportunities for us to work together to improve accommodation options for people with mental health conditions to be more recovery orientated and support independent living.

We know that people with mental health conditions, people with learning disabilities, and people with autism continue to achieve poorer physical health, employment opportunities, opportunities for social connection, lower income, and poorer housing than the general population. This is compounded for some communities including people in poorer areas, and those from black and minority ethnic communities: parity of esteem for mental health continues to be a pressing challenge.

The **BLMK Mental Health Learning Disability and Autism Collaborative (MHLDA)** is a partnership between BLMK ICB, ELFT (East London Foundation Trust) and CNWL (Central and North West London NHS Foundation Trust) to deliver a **"one team"** approach to improve outcomes, quality, value, and equity for people with, or at risk of, mental health problems, learning disabilities and autism. Our vision puts a focus on place, with service user voice at the centre. It refocuses our efforts on addressing inequalities and unwarranted variation and working at scale where it makes sense to do so.

At the heart of the collaborative approach is to understand what the real issues are for local people and working together to deliver the solutions. Our priorities are set by service users, carers and our communities starting with, **'what matters most to service users and carers':**

- Improved communication.
- Access to care and support being appropriate and timely
- Care being more informed, consistent, connected, and seamless
- Better access to key resources and services which empower service users
- Care that is person-centred and tailored around the individual not the condition.

Specific areas which the MHLDA Collaborative will focus on over the medium to long term:

1. Development of **sustainable early intervention and crisis recovery pathways** for children, young people, and adults.
2. Develop capacity to deliver early local diagnosis and support for people with **autism and autistic spectrum disorder**.
3. Development and implementation of sustainable recovery-focused models of care for people with **complex needs**. This includes complex placements being provided within the ICB area as standard.
4. **Capital development in core services**, for example mental health inpatient development in Bedford.
5. Improving **physical health access and outcomes** for people with serious mental illness, learning disability and autism.

The MHLDA, **led by Mental Health Providers**, will involve all partners.

8. www.local.gov.uk/prevention-concordat-better-mental-health.

2 BLMK Children and Families – Incorporating the work of the LMNS

The BLMK Joint Forward Plan sets out some stark reminders of the problems we face for children and their families across our system:

- Too many of our children in BLMK live in **poverty**
- Over a third of children in BLMK are **overweight** – this is a key risk in for future health & wellbeing.
- Not all children and young people have **early key interventions** during primary school years to enable them to thrive (communication, diagnosis and support for dyspraxia, autism spectrum disorders, emotional resilience)
- There is more we can do to **support transition to adulthood** for young people with complex needs
- Children and young people are **waiting too long** to access mental health and wellbeing services
- **Maternity inequalities** – poorer outcomes for BAME communities – higher risks mortality in this cohort in pregnancy. Higher risks of still birth, maternal, neonatal and infant mortality in 20% most deprived.

The **BLMK Early Years Seminar** in November 2023 brought together partners to further develop the four Place's Early Years Strategies. Each local Place has also launched a guide to help young people looking for mental health support. These represent commitment to the start of a long but critical journey to improve the lives and physical and mental health of our young people.

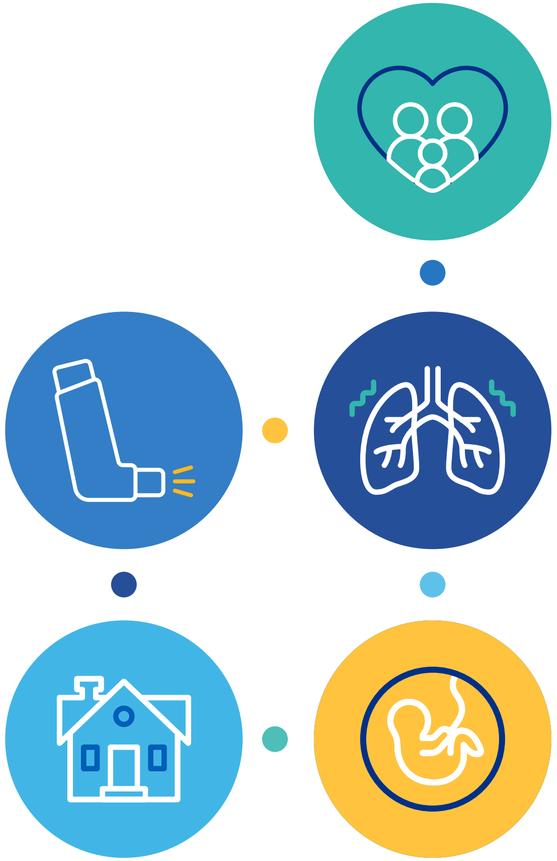
PRIORITY ACTION: Improving asthma management for children and young people with the highest risk of exacerbation, admissions, and poor outcomes

Hospital admissions for asthma for children and young people under 19 years old are significantly higher in BLMK when compared to England average, particularly in Luton.[9, 10] We aim to decrease the number of people with asthma diagnoses without record of spirometry, reduce the proportion of people with asthma who have an over-reliance on 'reliever' inhalers, and reduce the gradient of socioeconomic deprivation with respect to asthma outcomes. We will work to this aim through a range of interventions:

- Continue to encourage a **proactive approach to care**, with additional reviews for people with objective evidence of unmet need – improving outcomes and reducing inequalities
- Use **system alerts and tools** to support identification of cohorts for intervention
- Encourage evidence-based practice to avoid **SABA (Short-acting beta-agonists) overuse**, incentivising primary care partners to review those with frequent SABA scripts and address unmet need
- Encourage evidence-based diagnostics according to national best practice guidelines, continue to invest in **spirometry equipment and staff training** to perform spirometry.
- Explore further **digital education tools for children** about asthma and inhalers and learn from evaluations of current tools.
- Promote **greater adoption of inhaled therapies** for managing common respiratory conditions with reduced environmental impact.
- Build on existing work with partners across the ICS focused on the **wider determinants of health** e.g. the asthma friendly school scheme in Luton; housing and health group; working with Public Health teams on smoking cessation and work to address childhood vaping; outdoor air quality, green spaces and exploring the link between asthma management and outcomes with ethnicity and deprivation.

9. Office for Health Improvement and Disparities (data from 2020/21 – 22/23). Available at: Fingertips Public Health Data (accessed June 2024).

10. Data from Arden and GEM Clinical Support Unit.



BLMK Local Maternity and Neonatal System (LMNS)

The LMNS has a crucial role in ensuring women, babies and families receive safe, personalised and equitable care during pregnancy, childbirth and the early postnatal period. In BLMK this comprises of two hospital trusts, providing maternity and neonatal services across three hospital sites, two **Neonatal ODNs**[11], local **Maternity and Neonatal Voices Partnerships (MNVPs), Public Health** and wider partners.

Our vision is for maternity and neonatal services across BLMK is to offer safer, more personalised, and family friendly care, where our residents have access to the information they need to make the most informed decisions about their care.

Women and their babies should be able to access support that is centred around their individual needs and circumstances and our plan is committed to reducing health inequalities in maternity and neonatal care.

11. Operational Delivery Network: Developing Operational Delivery Networks (england.nhs.uk).

Below are the priorities which the LMNS has set out to deliver as part of this health strategy, in line with the NHS England Three-Year Delivery Plan for Maternity and Neonatal Services' four key aims:

1 Listening to women and families with compassion

- Involving service users in co-production of services by establishing local MNVP to ensure inclusion of the patient voice throughout the programme.

2 Meeting and improving standards

- Commissioning sustainable Smoke-free Pregnancy Pathways that reduce the number of women who smoke at time of delivery
- Preconception Care Programme offering support for mothers before pregnancy including managing a healthy weight and clinics to support with complex long-term conditions
- Social Prescribing to support pregnant women in East Bedford and Caritas Medical Primary Care Network, to increase uptake of early booking and engagement with maternity services
- Culturally Sensitive Genetic Risk Services Project improving access to genetic services and raising awareness – Luton is identified as one of 10 areas across the country for this pilot
- Supporting the implementation of **Neonatal Critical Care Review Action Plan**[12] priorities.

3 Developing and sustaining a culture of safety

- Promoting good practice for safer care including ambition for system wide delivery of the **Saving Babies Lives Care Bundle**[13] to reduce maternal and neonatal deaths, still birth and premature births
- Working to reduce variations for women from ethnic minority backgrounds, and those living in the most deprived areas
- Improving access to perinatal mental health services
- Improving prevention work with public health for poor outcomes and women's health before, after and during pregnancy
- Transforming neonatal critical care in partnership with specialist commissioning ODNs
- Development of an LMNS Dashboard to set out variation and inform Quality Initiatives
- Overseeing and monitoring the implementation of **Ockenden**[14] immediate and essential actions.

4 Supporting our workforce

- Working with NHS England to ensure the right skills and workforce to deliver against local workplans
- Developing the Maternity Support Workers programme across the Trusts
- Monitoring and implementation of the **Core Competency Framework for Maternity**[15].

12. Implementing the Recommendations of the Neonatal Critical Care Transformation Review - www.england.nhs.uk.

13. Saving Babies Lives Care Bundle - www.england.nhs.uk.

14. Ockenden report: Findings, Conclusions and Essential Actions from the Independent Review of Maternity services are The Shrewsbury and Telford Hospital NHS trust: assets.publishing.service.gov.uk.

15. Core competency Framework for Maternity: england.nhs.uk.

3 BLMK Cancer Board

The NHS Long Term Plan sets out clear objectives for how cancer services should be delivered to meet the ambition to transform cancer services. The **BLMK Cancer Board** established in 2017 has led the effective planning and implementation of strategic objectives for cancer services across the BLMK health economy and will lead this workstream.

The Board has four overarching focus areas:

1. **Preventing cancer** by addressing cancer risk factors
2. **Diagnosing more cancers early**, increasing the proportion of cancers diagnosed at stage 1 and 2 resulting in fewer cancers diagnosed as an emergency, and an increase in one and five-year survival rates
3. **Improving cancer treatment and care**. All patients should have access to high-quality modern therapeutic services. They will be cared for during and after their treatment, with increased support to live well after treatment. Patients will have a better experience of their care, with less variation across the country
4. **Proactive patient engagement** to ensure that the patient is at the centre of service delivery and their views actively sought and incorporated.

PRIORITY ACTION: Improving prevention, screening, and early diagnosis of cancer in women.

There is already a programme of work in place linked to delivery of the NHS Long-Term Plan and National Cancer Transformation Programme, however the variation in cancers affecting women has become a clear priority that will require a system lens to deliver and must therefore be a priority as part of our Health Services Strategy:

- Cancer is one of the **leading causes of death** in women
- Evidence suggests that cancer treatment is more successful and survival rates higher when the disease is **diagnosed early**[16]
- There is **variation in cancer screening uptake** including HPV vaccination
- **Mortality rates** from cancer are higher for women than men across all four of our Places within BLMK[17]
- Feedback received from women on **perceived barriers to accessing healthcare** give us insight to improve
- We see **increased risk factors linked to obesity**.[18]

Breast cancer is the most common cancer in the UK for women, accounting for almost a third (30%) of all female cases (2017-2019). The next most common are lung cancer (13%) and bowel cancer (11%). Cancers of the uterus and ovary are the 4th and 6th most common respectively.

Gynaecological cancer referrals to secondary care have increased significantly over the last 3 years. For the gynaecology urgent suspected cancer pathway, referrals are now at circa 150% of pre-pandemic levels impacting on cancer performance and increased demand for diagnostics. This rise in demand demonstrates the need to be able to appropriately triage, confirm or rule out cancer quickly to avoid unnecessary anxiety for women.

In November 2023 the NHS made a pledge to **eliminate cervical cancer by 2040**. To meet this challenge, the NHS needs to ensure as many people as possible are being vaccinated against the human papillomavirus virus (HPV) and coming forward for cervical screening.

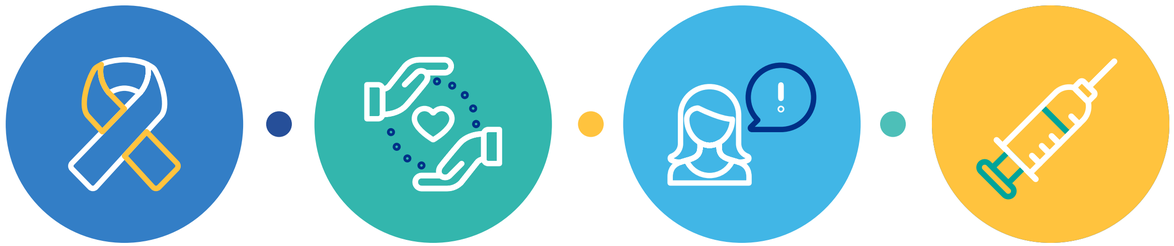
The rates of cancers linked to infection with certain forms of HPV are increasing, making them among the fastest growing challenges. Across BLMK, HPV vaccination uptake of two doses in both males and females aged 13-14 years old is significantly lower than England average and this pattern is seen across all our four Places.[19]

16. Cancer Research UK. Available at: Why is early cancer diagnosis important? | Cancer Research UK. (Data sources referenced: 1. Office for National Statistics. Cancer survival in England: adult, stage at diagnosis and childhood - patients followed up to 2018. 2019 2. National Institute for Health and Care Excellence (NICE). Suspected cancer: recognition and referral. 2021. 3. NHS Digital. Cancer survival in England; cancers diagnosed 2015 to 2019, followed up to 2020. 2022).

17. BLMK Place Based Profiles, 2022 refresh document.

18. Cancer Research UK. Available at: Overweight and obesity statistics | Cancer Research UK (accessed July 2024).

19. Office for Health Improvement and Disparities (data from 2022-23). Available at: Fingertips Public Health Data (accessed June 2024)



Early Detection Opportunities:

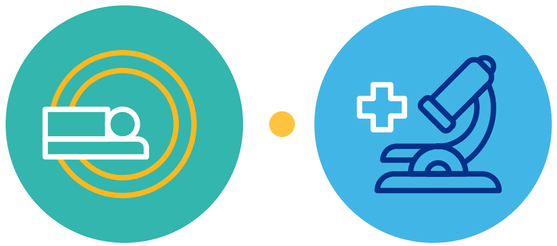
Cancer screening is an example of secondary prevention[20], designed to detect cancer early, increasing the chances of successful treatment outcomes.

In England, there are three national screening programmes:

- **Bowel cancer** screening offered every two years to those aged 60-74
- **Breast cancer** screening offered to women aged between 50 and 70 years
- **Cervical cancer** screening available to women and people with a cervix aged between 25 and 64 years in England. Cervical cancer is the most common cancer in women under 35. If all eligible women attended cervical screening regularly, **83% of cervical cancer deaths could be prevented.**

Targeted **lung cancer screening** has recently been recommended by the UK National Screening Committee, advising that screening be offered to the high-risk group of people aged 55 to 74 years with a history of smoking.

In BLMK, with the exception of breast cancer, uptake of cancer screening has been below the England average over the last 10 years. In the younger cohort (age 25 to 49) for cervical screening and bowel screening, there is some correlation between uptake and deprivation.



Opportunities for improvement:

- Increased focus on **preventing** cancers in women – interventions such as smoking cessation programmes, HPV uptake and tackling rising obesity
- Finding more ways to help women **recognise cancer signs** and the benefits of national screening programmes, particularly for communities who do not typically come forward, increasing the risk of late presentation
- Encouraging awareness and continued adoption of **NICE guidelines** amongst primary and secondary care clinicians
- Having the right **screening and diagnostic capacity** and resource for the projected rise in need for services – building an agile workforce that can flex across organisation, sector, and geographical boundaries to make sure this is not a cause of avoidable delays in diagnosis and treatment
- Intelligent use of **population health data** to understand the future incidence of cancers that affect women to plan service provision and proactive targeted intervention to better serve areas with poor outcomes
- There is good compliance against the 62-day standard for cancer treatment from point of referral for Breast cancer. However, we have more work to do to improve performance for **Gynaecology, Lung**, and **Colorectal** treatment pathways:
  - Continued **innovation** to support personalised, targeted treatment of cancer such as genetic testing and use of AI, ensuring seamless embedding and scale across the system to avoid a "postcode lottery"
  - **Improved access** to radiotherapy and other oncology services as well as clinical trials.

This work programme will be led by the **BLMK Cancer Board** and will in particular involve **Primary Care** partners who are major participants in the work of the Board and will inevitably play a critical role in working towards a proactive and preventative approach to treating cancer.

20. Secondary prevention: systematically detecting the early stages of disease and providing treatment before full symptoms develop.

4 Long Term Conditions – Health optimisation

Healthy life expectancy varies significantly across BLMK. In Central Bedfordshire, men can expect to live healthily until the age of 68 on average, whilst in Luton, only 59 years of age. Whilst the life expectancy of men in the two places differs by only 2.5 years, the men of Luton can expect over 6 years more living in ill health. Often, people will have several co-existing long-term conditions and the impact of these on quality of life may be cumulative.

The burden of long-term conditions is significant, and the management of each is increasingly complex. We have developed a system in which the role of the clinical specialist is much valued: however, **patients with multiple long-term conditions often benefit from the input of an expert generalist clinician**. General practice and broader primary care are under significant pressure in the context of this burden and ever-growing volumes of relatively straightforward 'transactional' urgent care demand which prevent the required focus on optimal long-term disease management.

The **long-term conditions programme** will bring partners together to ensure that the prevention agenda and the optimal management of long-term conditions are championed. It will work to ensure that contracts, funding, and primary care expertise are aligned to the needs of residents: receiving care from the most appropriate member of the team as close to their home as is feasible. **Care delivery models should be determined by the needs and wishes of patients, and not by custom and practice**.

A key metric for this work will be a **reduction in premature mortality** (specifically, all-cause mortality under the age of 75 years). Cardiovascular disease (CVD), respiratory disease, and cancer are the leading causes of death across BLMK, and collectively they contribute the most to the life expectancy gap seen between our most and least deprived neighbourhoods.

The work undertaken beneath the umbrella of long-term conditions will iterate over time as there is a vast array of long-term conditions which would benefit from focused collaborative working. However, a surfeit of priorities results in a failure to prioritise anything.

Initial areas of focus which will be confirmed by the priority work programme are likely to include:

1. Identifying hypertension in the population and treating effectively to target – BLMK is the poorest performing ICB in the country at **treating people with known hypertension to target** for their age group
2. Reducing the prevalence of **musculoskeletal (MSK) conditions** and improving timely management
3. Reducing number and duration of **admissions to hospital with heart failure – Age-standardised rates of admissions to hospital with heart failure in 2023 were higher in BLMK than any other ICB in the East of England (data from the East of England Cardiac Clinical Network). The optimisation of medicines for heart failure, particularly SGLT2i and MRA, is currently suboptimal**
4. Optimising information and access for residents living with long-term conditions through roll out of the **NHS App**.

PRIORITY ACTION: Improving identification of hypertension in the population of BLMK and treating effectively to target

Across BLMK, **approximately 40% of people with hypertension are not managed to their BP target**.[21] There is significant variation between deprivation deciles and between both primary care networks and practices across BLMK. Improving hypertension management is the area of greatest potential for BLMK to prevent future CVD events and deaths and will undoubtedly have a beneficial impact on other areas of secondary prevention, including lipid management and care for people with diabetes.

Work on this has already begun in Primary Care and significant steps forward have been made:Encouragement of **population health management approaches** in primary care for managing long term conditions, including hypertension, with resourcing through the **BLMK Primary Care Framework**.

- Rollout of the **BLMK Hypertension Protocol**, recommending evidence-based approaches to treatment with optimal efficiency, thereby minimising therapeutic inertia, loss to follow-up and health service utilisation
- Local **incentivisation to BLMK GP practices** for BP recording in people with hypertension, noting that higher levels of BP recording are directly linked to higher levels of treatment to target
- Commissioning of **SMS-based tool to support self-monitoring** of blood pressure, medication concordance, lifestyle change and data recording in GP systems
- **Additional capacity** for clinical reviews to manage blood pressure through place-based inequalities funding in Bedfordshire.

21. CVD Prevent. Available at: cvdprevent.nhs.uk (accessed June 2024)

We aim to improve further blood pressure monitoring and recording for people with known hypertension, and to increase the proportion of people treated to NICE-recommended targets (aiming for >80% by end of 2025), whilst also reducing the gradient by socioeconomic deprivation. There will be a particular focus on high-risk groups of people with hypertension – such as those with known cardiovascular disease, diabetes, or renal disease. Specific areas of focus to achieve this include:

- Enhanced upstream detection and intervention in respect of the **risk factors associated with hypertension** (including smoking cessation, weight management and support for drug and alcohol misuse)
- Working with ICS partners to **increase referrals to preventative services**
- Encouraging increased recording of blood pressure (BP) in people with known hypertension. Continue ongoing work between the ICB, Primary Care Networks (PCNs), practices and public health to encourage a **proactive approach to care**, using population health management tools to support the identification of people who have not had their annual review
- Expanding and identifying further opportunities for funding to provide reviews for people with objective evidence of **unmet needs**
- Greater awareness and use of the streamlined **BLMK Hypertension Protocol**
- Increased use of existing SMS-based tool and further digital technology to support BP management including tools to help people with **home recording and self-management**.

PRIORITY ACTION: Reducing the prevalence of musculoskeletal (MSK) conditions and improving timely management

Across BLMK there are **approximately 80,000 referrals made each year into community MSK services**. MSK conditions are a leading cause of disability and sickness absence across BLMK, with significant inequalities by deprivation and ethnicity.[22, 23, 24] We know that MSK conditions are more common in older age groups,[25] therefore we predict a significant increase in demand for MSK services with the forecasted demographic change in our population which is outlined in the foreword of this strategy.

Currently MSK services vary across BLMK, and there is the opportunity for redesign to improve outcomes, as well as patient experience, whilst navigating through what is currently a complex pathway. In partnership with **HealthWatch** we have undertaken resident and stakeholder engagement, both with general population and underrepresented groups, to understand views on the current services and to identify key themes for improvement. This will support the co-design of the service specification going forwards as we work to optimise the service offer in BLMK for people with MSK conditions:

- Have a stratified care model, where the level of intensity of support is dependent on the level of a service user's complexity and have a personalised approach for the service user. This model will:
  - Have a greater focus on **preventing** key risk factors associated with MSK conditions including, smoking cessation, support with weight management, menopause support. Health professionals will have access to health promotion materials and knowledge of the local and national preventative services available, and patient information will be available to empower service users.
  - Promote **self-care, earlier intervention, and timely access to appropriate interventions** (surgical and non-s urgical) and fostering prehabilitation and rehabilitation. Identify how service users wish to be communicated with and have adaptable resources and communication channels to meet service users' needs.
  - Provide a responsive service which will see the person as a whole. In particular, for those with additional mental or physical health conditions, identify a **spectrum of needs in order to develop a bespoke and complete treatment plan**. For example, this might include referral for talking therapy or signposting to local physical activity offers.

The work of the long-term conditions programme will continue to build on this work. It will be **led by Primary Care and the Integrated Care Board** and will involve all partners.

22. Global Burden of Disease Study, CBD Compare. IHME. Available at: vizhub.healthdata.org/gbd-compare (accessed August 2024).

23. Official Census and Labour Market Statistics. Nomis. 2018. Available at: www.nomisweb.co.uk/datasets/besa (accessed 2024).

24. BLMK Work, Worklessness and Health completed by Public Health Evidence and Intelligence team. Data sources include: HSE. Work-related musculoskeletal disorders statistics in Great Britain, 2021. Available from www.lancashire.gov.uk and HSC HSE's Health & Safety at Work Stats for 2021/2022 Are Here (2022) Available from: hcssafety.co.uk.

25. Office for Health Improvement and Disparities. Musculoskeletal health: local profiles. Available from: fingertips.phe.org.uk (accessed 2024)

5 Improving urgent and emergency care (UEC) and reducing unnecessary hospital stays

We are all aware of the unrelenting pressure on urgent care and increases in the number of non-elective admissions to the acute hospitals. This pressure has direct cost and opportunity cost in relation to the negative impact on planned care. Unnecessary admissions to an inpatient environment cause deconditioning, institutionalization, and loss of independence for residents.

Up to 20% of emergency hospital admissions are avoidable with the right care in place. Improving and supporting the capability of primary care and community-based services to avoid admission and hasten discharge is vital in the context of growth projections for the older population. Collaborative team working, managing clinical risks across the system aligned with the patient (rather than within the silo of an organisation) will be key to this work.

Initial areas of focus will be:

- Development of services which aim to **avoid overnight hospital admissions**
- Expansion of **virtual ward services** with a focus on outcomes and value for money
- Positively identifying those likely to be in the final two years of life and **improving end of life care**
- Supporting the growth of **new care models** focusing on local need and development of integrated neighbourhood teams.[26]

26. Integrated Neighbourhood Teams based around Primary Care Networks, which is part of the BLMK response to the Fuller Stocktake Report.

The Improving UEC programme, **led by Local Authorities, Acute and Community Providers**, will involve all partners.

6 Fragile Services – access to secondary care, critical mass, peer support and learning

Clinical services may be fragile for many reasons including workforce, finances, and quality. Some services may struggle to reach or maintain a critical mass in the modern context of clinical acuity, working patterns and sub-specialisation. Our context in BLMK is an unusual one; we do not have a traditional tertiary centre[27], and our geographical situation within the 'golden triangle' can be seen as both a gift and a curse.

In the recent past, the environment has not encouraged acute providers to share their challenges or operational weaknesses. **Now, in 2024, shared data and peer benchmarking, although imperfect, represent major steps forward in understanding our challenges as a system:**

- We need to make meaningful attempts to **understand significant variation** between local services (in relation to cost or quality outcomes) so that we can identify pragmatic improvement actions
- We use large numbers of **premium temporary staff** across our services, without first exploring the potential for mutual aid from peers
- Neighbouring services are not routinely looking at their granular performance data such that **symbiotic support can be offered** in specific service lines.

The fragile services programme will work to ensure that services within organisations form links and connections with peers, and that apparently unwarranted variation is explored and understood. Through building relationships and trust, services will have the opportunity to learn from one another and over time, the potential to develop alliances, reducing the bureaucracy and duplication inherent in aspects of process and governance. There will also be an opportunity to understand variation within the services offered to residents by the various tertiary providers.

Initial areas of focus will include:

1. Laboratory sciences
2. Vascular surgery
3. Diagnostics
4. Ophthalmology
5. Audiology
6. Neurology
7. Dermatology.

The fragile services programme will predominantly involve the **Acute Providers**, forming the basis of a meaningful acute provider collaborative in BLMK. This work programme will subsume the current **Elective Collaboration Board**.

27. Tertiary care refers to "highly specialised treatment such as neurosurgery, transplants and secure forensic mental health services" (www.nhsproviders.org - © NHS Providers 2024).

Engagement in the development of the Health Services Strategy

The Health Services Strategy has been developed over the course of 2023 and 2024 and belongs to the organisations providing publicly funded health services in BLMK – many of which are partners in the BLMK Health and Care Partnership. These organisations have been involved in the inception and development of the strategy. The local authorities, which provide public health services and are key partners in the delivery of joined up health and social care, have been engaged as key stakeholders.

We have engaged with leaders of these organisations over a period of several months and the strategy has matured by iteration.

In addition to these specific engagement sessions, colleagues from across the system have contributed their thoughts and ideas on the strategy as it has evolved. The strategy is richer as a result.

Table 2: Key engagement sessions have included (non-exhaustive):

Date	Event	Locality	Sector
17 Apr 2024	BHFT / ICB Board to Board Seminar	Bedfordshire	Acute
23 July 2024	BHFT Executive Group	Bedfordshire	Acute
04 July 2024	MKUH / ICB Private Board	Milton Keynes	Acute
01 July 2024	Session with Executive Leads of ELFT and CNWL	BLMK	Community and Mental Health
18 July 2024	Session with MK Joint Leadership Team	Milton Keynes	Place
23 July & 20 August 2024	BLMK Clinical Leaders and PCN Clinical Directors Meeting (including representatives of Local Medical Committees, LMCs)	BLMK	Primary Care
31 July 2024	ICB Executive Meeting	BLMK	ICB
19 & 30 August 2024	Sessions with ICB Non-Executive Members and Primary Medical Services Providers Partner Members	BLMK	ICB and Primary Care
29 Aug 2024	Place Board	Central Bedfordshire	Place
09 Sep 2024	Executive Delivery Group (BBC)	Bedford Borough	Place
10 Sep 2024	Place Board	Luton	Place
13 Sep 2024	Quality and Performance Committee	BLMK	ICB
19 Sep 2024	Health and Care Partnership Meeting	BLMK	ICB
19 Sep 2024	BLMK CEO Group Meeting	BLMK	ICB
27 Sep 2024	Integrated Care Board Meeting	BLMK	ICB

Implementation of the Health Services Strategy

This strategy will be presented to the Board of the ICB for formal adoption. Once adopted and published, we will move to the implementation of the Health Services Strategy which will initially focus on the setting up, reshaping, and resourcing of the six priority work programmes (delivery vehicles) and the **Health and Care Professional Leadership Group (HCPLG)**.

Each of the six priority groups will develop an initial 24-month work programme with detailed goals around the initial areas of focus in this strategy and guided by **SMART** metrics. These will be presented to the Integrated Care Board within six months of the ICB's adoption of the strategy.

Establishing a culture of measurement and improvement is included as one of the 15 commitments of our strategy, and a focus will be to establish key clinical metrics to assess performance on and provide the board with clarity on how we are trying to move things at a population health level. Each of the work programmes will also wish to pay attention to **workforce modelling** and will be supported in this through the **BLMK People Strategy** and our **Primary Care Training Hub** as appropriate.

It is our intention to later publish a formal appendix to the strategy (within 8 months of its adoption) detailing these six SMART priority work programmes.

Next Steps – Building to 2040

As the work programmes evolve and grow, so too will their priorities. After the first 24-month cycle of focus initially laid out, the programmes will publish updated priorities and work plans for the next period. These will continue to iterate over time supported and guided by the Health and Care Professionals Senate. The workstreams will continue to provide updates to the Board of the ICB which will hold our organisations to account against the statements and commitments made within this strategy.

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 27 September 2024

Executive Lead: Dean Westcott, Chief Finance Officer

Report Author: Nikki Barnes, Associate Director of ICB & System Estates

Report to the: Board of the Integrated Care Board in Public

Item: 9 BLMK Infrastructure Strategy

Reason for report to the Board:

(a) Power to approve Strategy reserved by the Board

1.0 Executive Summary

1.1 All Integrated Care Systems were asked to produce Infrastructure Strategies earlier this year. Guidance from NHS England (NHSE) was published 27th March 2024 and ICBs were asked to submit a final Strategy by end of July 2024. These national timescales were likely to have been driven in part so that this exercise could inform the next Comprehensive Spending Review (CSR).

The BLMK draft Strategy was discussed by Board members in an informal session in July 2024 and was duly submitted in draft form to NHSE as per the deadline above. The ICB has committed to providing a final version of the Strategy to NHSE by the end of September 2024. This final version of the Strategy includes the full assessment of capital funding requirements, incorporating previous feedback from Board members.

Development of the BLMK Infrastructure Strategy has been overseen by the system Capital & Estates Oversight Group (compromising of Finance and Estates leads across system partners), supported by workshops which were held in each of the four Places in our system with estates and services leads at operational and strategic level.

The Strategy follows the national guidance and focuses on the 330 healthcare properties in BLMK and covers a ten-year period. It is an enabling Strategy to support delivery of the BLMK Health Services Strategy, which is also on the agenda for discussion at today's Board meeting (27th September).

The Strategy outlines a total capital funding requirement of £3bn for the next ten years, in order to maintain and grow the local healthcare estate, and to support achievement of Net Zero requirements. This Strategy both makes a case for additional capital investment, whilst also setting out a pragmatic plan of action based on what is likely to be within the system's gift to deliver.

This document is described as the first Chapter of joint infrastructure planning within our system, and notes that the focus will continue to expand and will be captured when the Strategy is next refreshed in two years, to reflect our evolving service priorities and the system's "One Public Estate" ambitions.

2.0 Recommendations

2.1 The Board is asked to **approve** the BLMK Infrastructure Strategy.

2.2 The Board is asked to **note** the risks to delivery of the Strategy, particularly:

i) inadequate capital funding for all services in the system;
ii) rapid rates of population growth, and funding allocations not keeping pace;
iii) the barriers to alternative investment models as a result of CDEL (Capital Departmental Expenditure Limits) and IFRS16 (accounting standard);
iv) the lack of an investment model for expanding and improving community and mental health estate given the nature of commissioning arrangements and the high percentage of leasehold properties;
v) the challenges of trying to prioritise competing calls on investment;
vi) the resource and governance implications of delivering the Strategy.

3.0 Key Implications

Resourcing	✓
Equality / Health Inequalities	✓
Engagement	✓
Green Plan Commitments	✓
BAF Risk	✓

3.1 Resourcing – The Infrastructure Strategy commits the ICB and partners to additional workstreams. Consideration needs to be given to how these workstreams will be resourced.

Equality / Health Inequalities – A key objective of the Strategy is supporting a reduction in health inequalities.

Engagement – The Strategy has been developed with input from all ICS partners. Engagement with service users will be required for many of the workstreams set out in the Strategy, particularly for any specific projects to relocate services. Further engagement is planned with Healthwatch and the Voluntary and Community Sector via existing ICB engagement mechanisms.

Green Plan Commitments – A key objective within the Strategy is supporting delivery of Net Zero Carbon ambitions and starting to protect facilities from risks of climate change.

BAF Risks – The Strategy will include mitigating actions associated with the following risks:

BAF004 Widening Inequalities
BAF007 Climate Change
BAF008 Population Growth

4.0 Report

4.1 **Context**

All Integrated Care Systems were asked to produce Infrastructure Strategies earlier this year. Guidance from NHSE was published 27th March 2024, with a deadline of end of July. These timescales were likely to have been driven in part so that this exercise could inform the next Comprehensive Spending Review (CSR).

Feedback from NHSE on the draft BLMK Strategy submitted in July is still awaited.

4.2 **Process**

An initial data gathering phase of the programme was completed during the first few months of this year, and this was followed by engagement across the system.

Whilst there is significant joint work taking place with wider partners, e.g. wider public sector and voluntary sector partners, it was agreed that the scope of this work at this stage would focus on the 330 healthcare properties in BLMK, in line with the national guidance. This version of the Strategy has been described as Chapter One of the BLMK infrastructure ambitions, and it is planned that wider ambitions and activities will be captured when the Strategy is refreshed in 2026.

Workshops were held in each (Local Authority) Place during May 2024, which were well-attended by a combination of Estates, Place and Service Leads across partners. Discussions were supported by detailed Information Packs for each Place (summarised in Appendix B). Finance colleagues across the system supported the development of the accompanying Capital Template (Appendix C).

This Strategy both makes a case for additional capital investment, whilst also setting out a pragmatic plan of action based on what is likely to be within the system's gift to deliver. Implementing the Delivery Plan in this Strategy will require:

- Strengthened governance at Place level, to support delivery of priority healthcare projects, and to best facilitate a One Public Estate approach to support joint infrastructure planning as our service strategies and partnerships evolve.
- Additional resources for a range of actions and projects, both in terms of funding and people. Delivery of these resource requirements will be subject to affordability, and may require access to external funding opportunities.

5.0 Challenges

5.1 The Strategy notes that the greatest risks to delivery are largely outside of the ICS's control – particularly funding challenges. Members of the Board are asked to note the key constraints which risk delivery of the Strategy, particularly:

i) inadequate capital funding for all services in the system;
ii) rapid rates of population growth, and funding allocations not keeping pace;
iii) the barriers to alternative investment models as a result of revenue funding constraints, CDEL (Capital Departmental Expenditure Limits) and IFRS16 (accounting standard);

iv) the lack of an investment model for expanding and improving community and mental health estate given the nature of commissioning arrangements and the high percentage of leasehold properties;
v) the challenges of trying to prioritise competing calls on investment;
vi) the resource and governance implications of delivering the Strategy.

5.2 The Strategy also concludes that the greatest opportunities lie in i) working together across the system in true collaboration; ii) making best use of what we have; and iii) developing and realising partnerships with local stakeholders to maximise opportunities in infrastructure development across One Public Estate.

6.0 Next Steps

6.1 Submission of Infrastructure Strategy and Capital Template to NHSE end of September, and publication of Infrastructure Strategy on BLMK ICB website.
6.2 Development of work programme by October, with delivery to be overseen by CEOG with annual progress reports to ICB Board.
6.3 Implementation of strengthened governance within each of the four Places by April 2025, including approach for broadening the One Public Estate focus.
6.4 Development of next Chapter of Infrastructure Strategy by 2026.

List of appendices

Appendix A – BLMK Infrastructure Strategy
Appendix B – Place Profiles
Appendix C – Capital Template
Appendix D – Disposals Template

Background reading

NHS England » Guidance on developing a 10-year infrastructure strategy

Bedfordshire, Luton and Milton Keynes Integrated Care Board

Date: 27 September 2024

Executive Lead: Nicky Poulain, Chief Primary Care Officer, BLMK ICB

ICS Partner Lead: Joe Harrison, Chief Executive, Milton Keynes University NHS Foundation Trust

Report Author: Amanda Flower, Deputy Chief Primary Care Officer, BLMK ICB

Report to the: Board of the Integrated Care Board in Public

Item: 10 Utilisation of the NHS App in BLMK

Reason for report to the Board:
Report was requested at the Board seminar in April 2024.

1.0 Executive Summary

1.1 The NHS App was launched in 2019. It was widely used by the population during the COVID pandemic for the booking of vaccinations and to access vaccination certificates.

1.2 Since January 2023 there has been a national programme of work to relaunch and develop the NHS App as a simple and secure way for residents to access a range of NHS services. Over this period the NHS App has seen a huge increase in usage nationally with more than 40 million log-ins last month alone, with 1:7 of the population using it in-month. Functionality continues to increase and clear evidence is emerging that concerns regarding digital inequalities are not being evidenced at this stage. The NHS App is being used most by the lower socio-economic groups, with the highest age group usage in those over 65 years old.

1.3 The national threshold for '% GP Patients registered for the NHS App' is 60%. As of July 2024, the BLMK position against this threshold is 53%. BLMK is expected to reach the 60% threshold by June 2025. There is considerable variation across the four places, ranging from achievement in July 2024 in Milton Keynes and, projected achievement for Luton in May 2026.

1.4 This paper seeks the Board's agreement to five priority areas of action on which system partners will focus, until at least 31st March 2025, in a coordinated effort to increase utilisation:

- Educating NHS providers/staff on the benefits of the NHS App.
- Encouraging all residents who register a pregnancy (either with a GP or with the ante-natal midwifery team), to use the NHS App[1]. If we can engage those who are pregnant with the benefits of the NHS App this may lead to utilisation for their children (via linked profiles).
- Maximising the NHS App functionality for repeat prescriptions. 32% of residents in BLMK ICB had a repeat prescription during the last 3 months. There is the potential to

[1] (In 2023/24 there was a total of 11,889 births at Bedfordshire Hospitals NHS Foundation Trust and Milton Keynes University NHS Foundation Trust

reduce requests via the telephone to general practice teams and to support patients and their carers to take more control of their care.

- Work with all 84 general practice teams to review how they are using the NHS App for appointment booking and to navigate patients to access test results or health records. Targeted support to be provided to those practices who are not yet using the NHS App for appointment booking.
- Development of NHS App launch days in all four places (currently being diarised between 11th October 2024 and 31st March 2025), to publicise the benefits of the NHS App and encourage people to download, sign up and use.

2.0 Recommendations

2.1 The ICB Board members are asked to.

a. **agree** the five proposed priority next steps to increase NHS App utilisation in BLMK;

b. **discuss** the report and **suggest** further opportunities for increased NHS App utilisation in BLMK.

3.0 Key Implications

Resourcing	✓
Equality / Health Inequalities	✓
Engagement	✓
Green Plan Commitments	✓
BAF Risk	✓

3.1 Utilisation of the NHS App will support improved self-management for the entire BLMK population but specifically for those with existing conditions and for those impacted by inequalities. Whilst the NHS App is currently only available in English, we know that from the 2021 Census English was a first language in 87.4% of Beds Borough, 97% in Central Beds, 76.5% in Luton and 87.2% in Milton Keynes. Lobbying will continue to extend the language base in the NHS App.

3.2 A simple and continual communication approach is required to support our residents with education and engagement with the benefits of the NHS App. We need to ensure all staff/providers adopt a 'make every contact count' approach – we all promote the NHS App at every opportunity.

3.3 The implementation will utilise digital first where appropriate which will have a positive impact for the ICB's Green Plan.

3.4 Colleagues consulted in developing this work: the BLMK ICB Board, Primary Care Commissioning and Assurance Committee, the Primary Care Delivery Group, the Working with People and Communities Committee, the four Place Boards, PCN Clinical Directors, Strategic Primary Care Clinical Leads, Place Primary Care Clinical Leads and others.

4.0 Report

Context

4.1 The vision for the NHS App is to provide all residents with a simple and secure way to access a full range of NHS Services including digital access to their health care records – essentially providing a front door to the NHS.

4.2 Used to its potential the NHS App will:

- Support health promotion, enabling patients to improve their own health through pursuing a healthy lifestyle.
- Empower those with long term conditions to take greater control of their health and support self-management.
- Be an enabler to improved resident experience of access.
- Provide a better value option for the NHS.

4.3 To use the NHS App in England you must be 13 years or over and be registered with a General Practice team.

4.4 The scope of potential (not every function is currently available to every resident), utilisation of the NHS App is summarised in the following table:

Existing Features	**Existing Functionality**
View prescriptions and order repeat prescriptions (primary care)	• View current prescriptions. • Order repeat prescriptions. • Access barcode for prescription collection
Patient enquiries to healthcare providers in the NHS App	For practices using TPP (all of BLMK) and EMIS there is a secure messaging facility for patients to contact their practice team – recommended for non-urgent messages.
Registering with a practice	Patients can use the NHS app to register with a practice.
GP health records	Enables patients to view new health information in the GP health record.
Notification and messages to patients	Patients can receive in-app messages from their surgery, instead of other (more costly) methods like SMS (text messages) or letter.
Linked profiles and proxy access	This allows access for parents of children or for other caring arrangements.
Waiting time in the NHS	Provision of information regarding the mean (average) waiting time for patients referred into a specialty.
Hospital appointments	• View referrals and appointments • Single point of contact with regard to appointments • Provision of information to support appointments. • Book, change, cancel appointments. • Receive notifications and messages. • Complete requests for information/questionnaires • Access relevant documents • Select paperless preferences in relation to aspects of care

National Strategy

4.5 There is a stated aim to enable one third of all transactions to take place digitally, with the NHS App leading the way on enabling and empowering residents to take more control of their health and/or illness.

4.6 The Government is committed to three significant shifts in health and health care.

- Moving care closer to home
- Improving prevention and
- Greater use of technology.

As part of the Government's campaign to empower the public when they use public services the NHS will literally place itself in the hands of the public through extending the use of the NHS App. To achieve this the NHS app will become the primary method for the resident to engage with the NHS.

Progress in BLMK

4.7 The National threshold for '% GP Patients registered for the NHS app' is 60%. As of July 2024, the BLMK position is 53%. The regional position is summarised in the following table:

Regional Benchmarking	
% of GP Patients Registered	**At Jul-24**
Threshold	**60%**
Herts & West Essex	61%
Mid & South Essex	57%
BLMK ICB	**53%**
Cambridge & Peterborough	54%
Suffolk & North East Essex	54%

4.8 There is significant variation in the trajectory for each of our places to meet the '60% of GP Patients registered' for the NHS App. Whilst BLMK is expected to meet 60% in June 2025 this will not be reached in Luton until May 2026. It was achieved in Milton Keynes in July 2024. Appendix A provides the BLMK and place trajectories.

4.9 The table below show the 5 highest and 5 lowest practices across BLMK ICB where patients are logging into the app.

Practices with highest utilisation per 1,000			Practices with the lowest utilisation per 1,000		
Practice	**Place**	**Logins per 1,000 list size**	**Practice**	**Place**	**Logins per 1,000 list size**
Newport Pagnell Medical Centre	Milton Keynes	854.0	Malzeard Road Practice	Luton	87.7
Watling Vale Medical Centre	Milton Keynes	670.7	Ashburnham Road Surgery	Bedford	89.3
Sandy Health Centre	Central Beds	568.8	Neville Road Surgery	Luton	106.9
Hilltops Medical Centre	Milton Keynes	519.4	Conway Medical Centre	Luton	110.6
Walnut Tree Health Centre	Milton Keynes	517.9	Linden Road Surgery	Bedford	127.1

4.10 Utilisation of the NHS App is an enabler to improve access, particularly where patients can access test results and book appointments as this is likely to reduce telephone calls to practices. Education sessions are available to all practices in BLMK regarding the NHS App with the opportunities highlighted and explained. The current utilisation of the NHS App by practices is shared, including where practices are using the NHS App for appointment booking. A learn and share approach is being facilitated.

4.11 There are known barriers which negatively impact our progress, these include:

- There is no significant funding available for e.g. a large-scale public communications campaign.

- Resources to support promotion outside of health settings, for example schools, 6th form colleges, libraries etc are limited; this needs to be extended if we are to achieve the potential of the NHS App in facilitating self-care.
- Parents struggling to use the NHS App for their children's care (often because they have to visit their practice to register for proxy access for children for safeguarding reasons).
- The NHS App is currently only available in English, which limits its usage in Luton in particular, and this runs contrary to our approach in responding to the Denny Review.
- Mobile phone coverage in parts of Central Bedfordshire is very patchy.

5.0 Next Steps

5.1 This paper presents five priority actions, for focus until 31st March 2025, for the Board's agreement, to drive up utilisation of the NHS App in BLMK:

1. Educating NHS providers/staff on the benefits of the NHS App. This will be initially focussed on community pharmacists and general practice teams through a range of sessions such as meetings with practice teams, practice managers, and protected learning time sessions.
2. Encouraging all residents who register a pregnancy (either with a GP or with the ante-natal midwifery team) to use the NHS App[2]. If we can engage those who are pregnant with the benefits of the NHS App this may lead to utilisation for their children (via linked profiles). The ICB will work with midwifery and obstetric teams to ensure they have adequate training and understanding and have access to information to share with residents.
3. Maximising the NHS App functionality for repeat prescriptions. 32% of residents in BLMK ICB had a repeat prescription during the last 3 months. There is the potential to reduce telephone requests to general practice teams. This change supports patients and their carers to take more control of their care.
4. Work with all 84 general practice teams to review how they are using the NHS App for appointment booking and to navigate patients to access test results or health records. Targeted support to be provided to those practices who are not yet using the NHS App for appointment booking.
5. Development of NHS App launch days in all four places (currently being diarised between 11th October 2024 and 31st March 2025), to encourage and help people to download the App and to publicise its benefits.

Appendices

Appendix A BLMK and Place Trajectories to Meet 60% Threshold

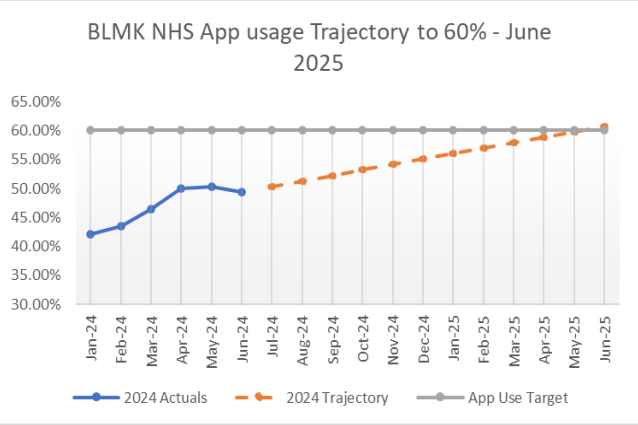
Background reading

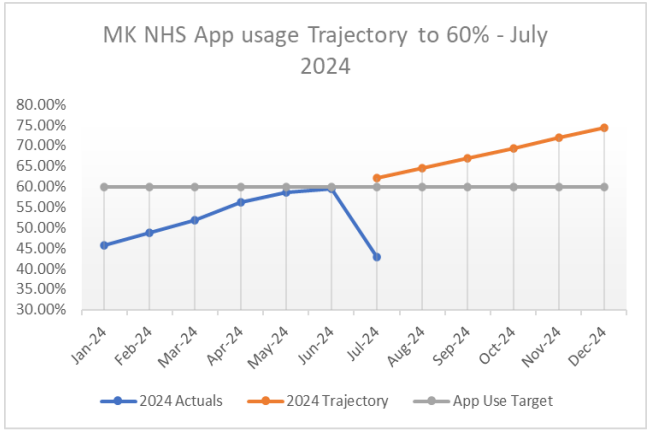
NHS Digital Roadmap NHS App roadmap - NHS App roadmap - NHS England Digital
NHS Digital NHS App walk through videos NHS App walk through videos - NHS England Digital

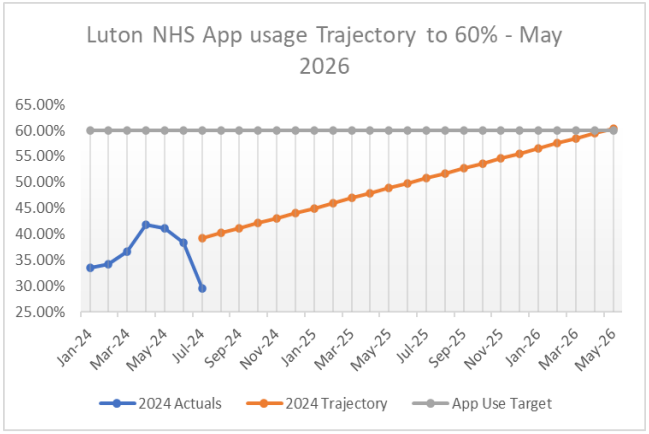
NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

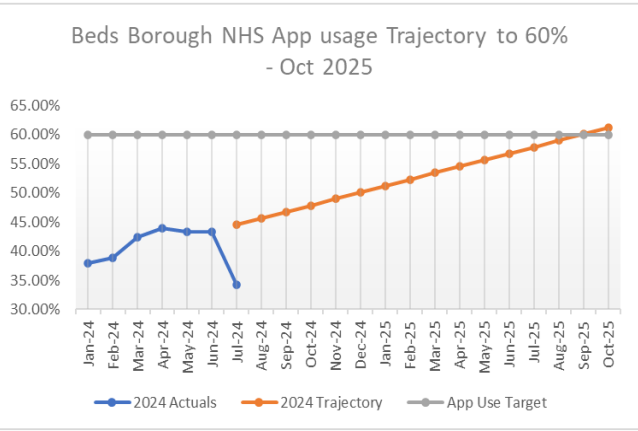
Appendix A

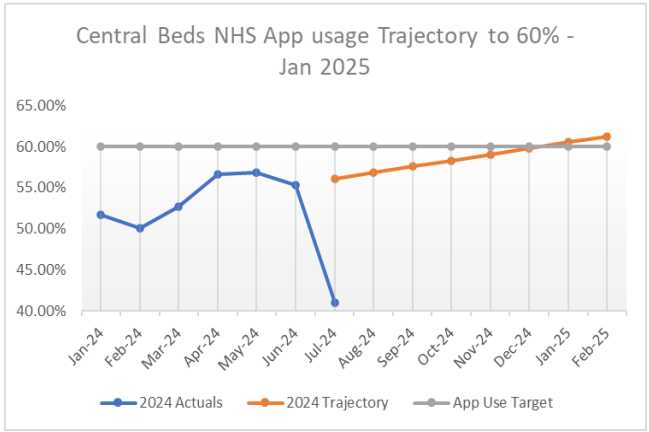
BLMK and Place Based Trajectories to Meet 60% Threshold











NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 27 September 2024

Executive Lead: Anne Brierley, Chief Operating Officer

Report Author: Anne Brierley, Chief Operating Officer and Michael Ramsden, Associate Director for Delivery

Report to the: Board of the Integrated Care Board in Public

Item: 11 Stay Well and Winter Plan

Reason for report to the Board: Requested by the Board in July 2024.

1.0 Executive Summary

1.1 The paper builds on the Analysis of BLMK Acute Hospitals' Emergency Activity item at the July 2024 Board meeting. As the Board requested, this paper sets out more detail on the system's plans to support residents to stay well during winter.

1.2 The priority actions we are taking in partnership to prepare for winter pressures and deliver our strategic objectives for urgent and emergency care are outlined below. They build on partners' feedback, but also provide assurance to the Board that all parts of the BLMK system are supporting UEC winter readiness. The 4 actions are:

- **Support at Place** to help people stay well in winter (e.g. stay warm, stay connected) focusing on learning from last year how best to reach people most in need of support.
- **Preventative measures** including flu, covid and Respiratory Syncytial Virus (RSV) vaccination (GP and community pharmacy) and personalised care planning with self-management plans for patients with chronic respiratory airway conditions.
- **Improving flow along urgent and emergency care pathways** - access to same day urgent primary care (GP, dental and community pharmacy) and a range of transformational programmes in the Bedfordshire Care Alliance and Milton Keynes Improving System Flow Programme to reduce avoidable Emergency Department (ED) attendances, non-elective admissions and improve flow.
- **Winter planning communications: key principles and expected activity** on self-care for winter and how we will endeavour to give consistent messages to our staff across all settings and reach more residents than before.

This paper takes each of these areas in turn.

2.0 Recommendations

2.1 The Board is asked to:

a. **Note and support** the actions taken by partners to improve access to commissioned services, prevent admissions and improve UEC pathways, and **identify** if further actions are required.
b. **Discuss** opportunities to embed winter messaging communications throughout all our organisations, especially where we can raise awareness of VCSE support and preventative measures supporting our collective workforce to reach a greater audience.

3.0 Key Implications

Resourcing	✓
Equality / Health Inequalities	✓
Engagement	✓
Green Plan Commitments	✓
BAF Risks	✓

3.1 **Key Risks**

BAF Risk 003 – Pressure on UEC in the BLMK System – current score 16 (high). This risk has been subject to a dynamic risk assessment by all relevant system partners and has developed Key Risk Indicators to support more effective monitoring of, and response to, this risk this winter. More detail is provided in the System Risk Register/Board Assurance Framework report provided to the Board today. The NHS App Report also presented today describes how we are working to encourage residents to use the NHS App to reduce pressure on UEC services.

4.0 Report

4.1.1 The NHSE 'Winter and H2 priorities' letter (16th September 2024) outlines the steps NHS England is going to take, as well as those ICBs and providers are asked to take, to support the delivery of safe, dignified and high-quality care for patients this winter. The plans outlined in this report fulfil NHSE expectations of ICB and providers.

4.1.2 Health and Social Care partners continue to develop programmes aimed at improving Urgent and Emergency Care (UEC) pathways. UEC performance remains fragile and further work is needed to embed actions arising from the previous winters' experience and develop flexibility that allows partners to shift resources to the area of need.

4.1.3 This paper sets out the actions of this year's winter plan, which, when viewed as a whole, demonstrate how the whole system is working collaboratively to improve resilience. The priority actions are presented at Paragraph 1.2

4.1.4 While the primary objective is to keep residents safe and maintain a resilient UEC system, other strategic objectives include:

- Sustain or improve A&E performance - working towards 78% of patients being admitted, transferred or discharged within 4 hours (national target of 78% by March 2025).
- Improve category 2 ambulance response times relative to 2023/24, to an average of 30 minutes.
- Maintain the level of elective and UEC capacity delivered through 2023/24.
- Increase the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes.
- Continue to develop services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs.

4.1.5 The BLMK Urgent and Emergency Care (UEC) Planning and Assurance Group will play a critical role in monitoring progress against the Winter plan.

4.2 **Priority Area 1: Support at Place**

4.2.1 Partners at each of the four Places (Central Bedfordshire, Bedford Borough, Luton and Milton Keynes) play a critical role in supporting people to stay well in winter. The following sections outline the actions being taken by the four places which will help support winter resilience.

4.2.2 **Central Bedfordshire** – The Council is in the process of reaching out to the 23 warm spaces that were supported last winter to gather their feedback on how it went and to understand

their plans for winter 24/25. Bedfordshire Rural Communities Charity (BRCC) supports a network of Good Neighbour Schemes, these schemes are set up and run by local residents who offer help and support to fellow residents of their town or village.

BRCC offers a range of support services all year round to local people living in villages and market towns across Central Bedfordshire, the offer includes transport support to access Warm Spaces in the community. BRCC will be providing support for people who are likely to be affected by fuel poverty and who are socially isolated during the winter months.

BRCC have continued to run the Dunstable and Biggleswade warm space throughout the year and offers a range of support services that includes meals, opportunities to charge devices, keep warm wellbeing walks, social prescribing and gardening.

4.2.3 **Bedford Borough –** Feedback from the VCSE sector over the past two years has shown that Welcoming Spaces (formerly Warm Spaces) work best in an informal community setting with an additional offer, such as food/drink, a group activity, or space to charge a phone. Usually based in faith settings, community centres and social clubs, many groups now run all year round. For a third year, Public Health plan to provide up to £10,000 of grant funding for 'Welcoming Spaces' for winter 2024.

Residents are also supported to stay warm in their own homes through the Better Housing, Better Health scheme which offers individual assessments to support people to manage fuel challenges during the colder months. A number of social service provisions are increased in anticipation of winter pressures, many delivered through VCSE funded activity that include British Red Cross, Age UK and Carers in Bedfordshire. The support for residents in the community has a focus on prevention e.g. reducing carer breakdown and increasing awareness of support available. Specific support for patients in hospital and after discharge is provided for people to recover at home and avoid readmission. Around 300 hot boxes containing a blanket, gloves, hot water bottle etc. are delivered to vulnerable residents.

Bedfordshire Rural Communities Charity (Beds RCC) who provide social prescribing for Bedford Borough, will increase their Green Social Prescribing offer through winter. Providing additional Wellbeing Walks to keep people moving and connected; reducing social isolation, and physical health symptoms caused by inactivity. The Place team will be working closely with Council, health and VCSE colleagues to promote key information about what is available for residents through the Clinical Director and Practice Manager meetings, and with community engagement and VCSE colleagues.

4.2.4 **Luton** – We are taking a holistic approach to our winter plan in Luton. Our focus is working with and supporting our residents, communities to ensure they remain safe & well during the winter period and as a result prevent an escalation in system pressure, including admissions to the Acute, and increased demand on Primary Care and Social Care. In addition, we are staying close to our Providers and VCSE colleagues to facilitate connectivity and collaboration with their individual plans.

Our previous winter initiative, Warm Spaces has evolved into a year-round support offer. A number of established Hubs including the recently established Luton Community Hubs and Family Hubs, working closely with Partners, including the VCSE, offer support for those struggling with fuel poverty, requiring a warm space, support for social isolation and wider socio-economic needs throughout the year. We will continue to fund local VCSE discharge initiatives, including the Noah Homeless Discharge contract, providing temporary accommodation to facilitate supportive and timely discharge, drive forward referrals for housing and additional needs, including referrals for drug and alcohol needs, access to a postcode to support post discharge medication requirements, dedicated immigration process support for those with NRPF.

Further to this, the Luton Primary Care Networks are supporting people to stay well in winter, through care planning, organising awareness events and social prescribing. Luton Public

Health have local messages and articles on social media and local magazines and information in different languages about flu vaccinations with the aim of increasing uptake.

4.2.5 **Milton Keynes –** Milton Keynes City Council work in partnership with providers to achieve better outcomes for residents. This will mean less people residing permanently in residential and nursing homes, reductions in emergency hospital admissions and more people living independently in their own homes with less reliance on mainstream services. This will be achieved by seeking to ensure that all adults are supported to achieve this, developing a joined-up approach to services which support independence. Information is shared across all services within MKCC, and with partner organisations.

Due to the projected number of older people who are currently (or will be) living with dementia in Milton Keynes, we've put in place a robust offer to help people living with dementia, and their carers. This includes advice, support and services which are available earlier in their diagnosis and that will enable people to live at home for longer, which is known to enhance mental wellbeing. Regular awareness sessions delivered to the public, businesses and community organisations to enable them to become dementia friendly.

The Integrated Care Support Team (ICST) provides a coordinated and integrated approach to supporting individuals primarily over the age of 65 to manage their health and social care needs holistically working as collaborative multi-disciplinary team (MDT) with Primary Care Networks (PCN) (GP surgeries) across Milton Keynes to put in preventative measures to avoid hospital admission, frequent attendance at GP surgeries and to combat isolation.

4.3 **Priority Area 2: Preventative measures**

4.3.1 The Primary Care Prevention plan that was co-designed with Public Health promotes actions that reduce the risk of urgent presentations in urgent care services. A specific focus this year will be supporting vulnerable cohorts of patients and residents living in deprivation that miss out on being immunised year on year. There will be outreach vaccination activities to underserved communities and where possible, co administration of vaccinations.

4.3.2 Seasonal Flu Vaccinations:

- GP Practices have ordered sufficient flu vaccine to meet their patient needs and the ICB encourages collaborative working with neighbouring community pharmacist to immunise practice populations.
- All pregnant women and children will be offered flu vaccinations from 1st Sept 2024 and eligible adults will be offered vaccination from 3rd Oct 2024.
- The flu vaccinations programme will run until 31st March 2025.

4.3.3 Covid Vaccinations:

- All eligible patients will be offered Covid vaccinations from 3rd October and the programme is coordinated by BLMK vaccination and Immunisation Group.
    - Adults including all residents living and staff working in care homes and adults aged 65 years and over.
    - All persons aged 6 months to 64 years in clinical risk group, and frontline health and social care workers.

4.3.4 Respiratory Syncytial Virus (RSV) Vaccinations

- From 1st September, RSV vaccine will be routinely offered for residents over 75 years old and to pregnant women from 28 weeks of pregnancy.

4.3.5 Primary Care Access - Ensuring access to same day urgent care during the winter for residents is a priority in the winter plan and requires effective connectivity between 111 providers, GP practices and community pharmacists. Primary care Providers are encouraged to collaborate to maximise self-management plans for patients with chronic conditions and to utilise 'special patient notes' for complex patients. Direct access to secondary care pathways for high-risk complex patients is promoted via the Consultant Connect platform in Milton Keynes and the GP Liaison line and the Silver Line in Bedfordshire.

4.3.6 **GP Practices**

- All GP practices are developing capacity and demand plans with many implementing total triage enabling patients to know on the day they make contact how they will be dealt with (same day appointment, booked for a future appointment, directed to another service)
- All practices will be supported to access training to utilise their Cloud Based Telephony to manage calls more efficiently.
- Practices working together within a Primary Care Network (PCN) are planning for additional appointments over the winter period.
- Encourage patient use of the NHS App so secondary care appointments and health information can be accessed without needing to contact providers.
- Monitor practices use of the 'urgent community response' (UCR). Identity practices that may benefit from having greater awareness of this service.
- Monitor the number of care home residents being seen each month on ward rounds and in monthly multidisciplinary team meetings as per the requirement of the Enhanced Health in Care Homes, specifically in Older Age Care Homes. Increase the number of care home residents with a Personalised Care and Support Plan - to be monitored from the start of winter 2024 to the end of March 2025. The aim is to reduce the number of hospital conveyances and admissions from care homes.

4.3.7 **Integrated Urgent Care (IUC)**

- Increased resilience of 111 call handling capacity to reduce call abandonment rates.
- The BLMK Calls Abandoned targets (%) for winter 2024;

	Nov	Dec	Jan	Feb
2023/24 BLMK Calls Abandoned Actual (%)	7.7%	13.8%	12.4%	15.9%
2024/25 BLMK Calls Abandoned Target (%)	≤3%	≤3%	≤3%	≤3%

- The call abandonment performance will be monitored throughout winter.
- Monitor the 111 call volumes during the in hours period (08.00 to 18.30) and ICB to respond to unexpected peaks in call activity.
- Monitor the demand on the Clinical Assessment Service (CAS) and the GP Out of Hours services and respond to any unexpected over reliance on these services.
- Monitor the number of ambulances dispatched by IUC;

Ambulance Dispatches via IUC	Nov	Dec	Jan	Feb
2023/24 BLMK Total No. of C1 & C2 Ambulance Dispatches	2058	2082	1843	1643
2023/24 BLMK Total No. of C3 & C4 Ambulance Dispatches	1025	940	854	685
2023/24 BLMK Total No. of Ambulance Dispatches	3083	3022	2697	2328
2023/24 BLMK Ambulances Dispatched as a % of IUC cases triaged	12.23%	10.83%	10.62%	10.35%
2024/25 BLMK Target	≤10%	≤10%	≤10%	≤10%

- Monitor the number of patients signposted to attend A&E by IUC;

A&E Signposted Referrals via IUC	Nov	Dec	Jan	Feb
2023/24 BLMK Total No. of A&E Signposted Referrals	1209	1256	1272	2103
2023/24 BLMK A&E Signposted Referrals as a % of IUC cases triaged	7.45%	7.28%	8.19%	7.7%

2024/25 BLMK Target	*≤10%*	*≤10%*	*≤10%*	*≤10%*

- Monitor patient requests for repeat prescriptions from IUC services. Aim for winter 2024 (November to February) is to have a 5% reduction from in the number of calls via IUC requesting a repeat prescription. This will be monitored throughout winter.

- The ICB Primary Care Team will have continued oversight of the metrics and engage with partners where necessary.

4.3.8 **Pharmacy**

- Increase patient awareness of what conditions can be managed by pharmacy including:
    - Management of repeat prescriptions throughout winter
    - Pharmacy First –monitor referrals from general practice into Pharmacy First at a practice level – this will potentially release capacity within general practice for more complex patients.
- The integrated referral system is currently under pilot with 23 practices across BLMK signed up. In October 2024 the pilot sites will go live with the Pharm Refer software with the aim to increase referral rates by a minimum of 10% from the October 2024 baseline. This will be monitored throughout winter.
- Utilise the Community Pharmacy Engagement roles to help develop channels of engagement between community pharmacy and PCNs. The aim is to recruit 12 into the roles across BLMK with 3 per place.

4.4 **Priority Area 3: Improving flow along urgent and emergency care pathways.**

4.4.1 In Winter 23/24, periods of continuous pressures resulted in prolonged escalation. Feedback from partners emphasised actions were needed to strengthen resilience to avoid a repeat this winter. Suggested actions were:

- A review of all discharge to assess beds - enhancing occupancy rates and aligning capacity with demand and acuity.
- Reduce the length of time taken between discharge ready date (DRD) and actual discharge.
- Reduce the number and length of time mental health patients, with no criteria to reside, (nCTR) occupy community and acute beds.
- Develop unscheduled Care Hubs (UCCH) to improve access to the ambulance stack, embed Call before Convey for care homes, and an increase in referrals into Urgent Care Response team.
- Reduction in the number of days patients wait for discharge to a Care Home.
- Strengthened escalation processes with development of metrics that allow partners to identify early signs of emerging pressures.

4.4.2 With the support of partners, assurance is given to the Board that all the recommendations above have been embedded in Winter Plans. Actions include:

- Trend analysis of discharge to assess beds. Contract variations to ensure the number of beds does not exceed the need. Standard Operating Processes to apply consistency to spot purchasing additional beds.
- Mental Health escalation group and de-escalation events (see 4.46)
- Oversight of UCCH referral performance, remodelling the UCCH to achieve NHSE Minimal Viable Product, implement Call before Convey for care homes whilst promoting the services already available to them.
- New system wide escalation process, supported by the System Co-ordination Centre (SCC) and metrics to oversee deterioration in performance. Development of UEC predictive modelling tool.

4.4.3 Pathways that safely manage residents urgent and emergency care needs outside of secondary care are essential to containing anticipated winter pressures. The partnerships within the Bedford Care Alliance and Improving System Flow Group (Milton Keynes), together

with the ICB's SCC, have provided the foundation for UEC transformation, with strong collaboration between NHS and Local Authorities. The ICB's System Transformation Team are providing transformation capacity to support rapid improvements.

4.4.4 Improved data analysis is helping identify opportunities to manage care differently. The paper titled *'Winter - Analysis of BLMK Acute Hospitals Emergency Activity'* presented to the ICB Board on the 19 July 2024 highlighted several opportunities to avoid presentations to A+E. The Alternatives to ED (A-tED) audit will build on this, providing valuable information on where commissioned pathways are not understood or do not benchmark well against national standards. The outputs of this audit are expected in September and be presented to the UEC Planning and Assurance Group allowing time for the system to generate improvement actions.

4.4.5 The UEC Planning and Assurance group have agreed a smaller number of key metrics aligned to a dynamic risk assessment (see Board Assurance Framework report). Work has commenced to develop a predicative UEC modelling tool which allows the SCC to detect emerging pressures and instigate recovery actions early. The ambition is to have this tool developed ahead of winter, although further refinements will be needed as we learn what works well.

4.4.6 Mental health inpatient bed demand has exceeded local capacity, with discharge delays leading to (ELFT) remaining at OPEL 4 for most of 2024. Going into winter, plans are focused on improving flow and crisis prevention:

- Weekly escalation meetings to address discharge delays.
- Decompression week planned for September, including mapping current pathways and identifying pressure points.
- ELFT and BHFT to develop 'specialing' support, to reduce pressure on BHFT wards and length of stay.
- Progressing alternatives to admission (including a crisis house) and transforming community services.
- Improved management of supported independent living and complex placements for timely discharge and recovery.

4.5 **Priority Area 4: Winter planning communications: key principles and expected activity.**

4.5.1 As in previous years, communications activity will be based on the following principles:

- Preparation: We will build awareness of the measures that the NHS is implementing now to manage additional pressures and demand this winter. This includes a concentration on staff vaccination and greater resilience to potential workforce shortages in all parts of the NHS.
- Prevention: We will endeavour to influence public behaviour with a strong focus on vaccine uptake in advance of winter, and alternative routes of care during times of peak demand. In promoting access to urgent advice and emphasising options for self-care, we will also offer advice on financial support for health costs (such as prescription charges). We will be particularly keen to reach those who may be suffering from a form of 'vaccine fatigue' after the last few years, despite their inclusion in eligible cohorts; the VCSE sector will be of great value in maximising uptake among the most vulnerable.
- Performance: We will work with our partners in the health sector to co-ordinate a credible NHS response to all reputational risks during winter.

4.5.2 **Seldom Heard Groups**

- Working with the VCSE sector and places of worship will allow us to reach more people who don't have English as a first language and convey messages that might be mis-interpreted.
- Healthcare professionals will be invited to record videos in English and other languages, which could be shared via WhatsApp etc if patients and their families so wish.
- NHS staff, especially portering/catering/cleaning/reception workers, will be invited to share key messages in incidental interactions they may have with patients.

5.0 Next Steps

5.1 A system wide Staying Well and Winter Planning workshop on 13th September allowed partners from health and social care, including VCSE, to debate the plans to mitigate winter pressures. The attendees supported the actions outlined in this paper but concluded we need to continually challenge ourselves to ensure we are doing enough. The UEC Planning and Assurance Group will provide that function. VCSE partners also expressed an interest in the current co-ordination functions provided by the SCC and further work will follow.

The ICB will conclude its Winter Planning engagement in September with the final Winter Plan to be presented to the UEC Planning and Assurance meeting in October.

Bedfordshire, Luton and Milton Keynes Integrated Care Board

Date: 27 September 2024

Report Author: Vineeta Manchanda, Chair of Audit and Risk Assurance Committee

Report to the: Board of the Integrated Care Board in Public

Item: 12.1 Alert, Advise and Assure Report to the Board of the Integrated Care Board

Committee: Audit and Risk Assurance

Recommendation: The Board are asked to **discuss** the issues raised by the Audit and Risk Committee on 26 July 2024.

Key discussion points and matters to be escalated from the meeting.
ALERT: Matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the ICS strategy
• **None**
ADVISE: The Board of areas subject to on-going monitoring or development or where there is insufficient assurance
• **Freedom to Speak Up**. The Committee has sought further assurance on frequency of reporting and reporting lines for consideration of Freedom to Speak Up findings. • **Corporate Risk Register (CRR).** The Committee has sought additional clarity on corporate risk reporting, through the preparation of a risk "map" to clearly demonstrate where responsibility for specific risks sits within the ICB structure, and the different risk registers on which these recorded. The Committee has also requested assurance that risk system administrators are ensuring that risk owners are updating progress on the risk system in a timely manner. • **System Risk – Risk Management Policy and Framework.** The Committee considered a review of the policy and framework and made suggestions to provide further clarity of the risk management framework. **The Risk Management Policy and Framework is recommended to the Board for approval.** • **Internal Audit Plan 2024-27.** The Committee noted the Executive has requested that the advisory governance review for 2025-25 to cover arrangements at Place, and has advised that the Specialist Commissioning audit scope be referred to the Quality and Performance Committee to maximise NEM oversight and input into the audit. Subject to this the internal audit plan for 2024/25 was approved. A new process for involving NEMs in the scoping of internal audits was agreed and has been implemented. • **Patient Safety Incident Reporting Framework.** Further assurance has been sought on the monitoring of PSIRF reports by Q&P. • **Internal Audit Follow Up Report.** Overdue items from 2021-22 relating to Section 117 were referred to the Mental Health, Learning Disabilities and Autism Collaborative for consideration and report back to ARAC. • **Counter Fraud Reports.** The Committee approved the annual review of the anti-fraud and bribery policy. • **Single Tender Waivers/SMI physical health check contract**. The Committee has sought further assurance on the success and value for money of this contract in view of the low uptake and has referred it to the Quality and Performance Committee for their consideration. • **Urgent and Emergency Care (UEC) System Risk.** The Committee undertook a deep dive into this system risk in its part 2 meeting. UEC services are under pressure across the system, and considerable work is going into understanding the drivers of UEC pressure and the mitigations needed to alleviate that in collaboration with partners. This work is ongoing and will be brought back to the Board once consultation is completed and

the final version is agreed with partners.

- **Voluntary, Community and Social Enterprise (VCSE) Sector Sustainability: System Risk Assessment.** The Committee undertook a deep dive into this system risk in its part 2 meeting. This assessment is in its early stages of development, at a time when the VCSE sector is facing risks to its sustainability in a number of key areas, including finance and workforce. The sector plays a vital role in supporting the ICB and its partners in delivering its transformation agenda in areas such as reducing inequalities, and in supporting the community with their health and care needs, also reaching into smaller and isolated communities. At this stage the review focused on the problems to sustainability faced by the sector particularly by smaller organisations. The Chair requested that in the next iteration the focus should be on scoping the areas that the VSCE could help in delivery of health services or outcomes that the ICB and its partner organisations are responsible for. This risk should focus on the risk to the delivery of those health outcomes once they have been defined.

ASSURE: Inform the Board where positive assurance has been received

- **Counter Fraud and Cybersecurity.** The Committee received assurance that the ICBs IT function was robust in combatting cyber fraud, including the delivery of regular training to staff, and that the ICB was taking appropriate measures to mitigate the risk of cyber fraud.
- **Information Governance.** The Information Governance Team has made good progress in complying with the standards required by NHSE in this area.

RISK: Advise the Board which risks were discussed and any new risks identified

- **See above:** Corporate and System Risks, Patient Safety Incident Reporting Framework, Counter Fraud and Cybersecurity, Information Governance.

CELEBRATING SUCCESS: Share any practice, innovation or action that the Committee considers to be outstanding

- **Information Governance.** The Committee expressed its thanks to the team for its work to achieve compliance with NHSE standards and for the high level of assurance provided in its report to the meeting.
- **Board Assurance Framework (BAF).** The BAF has evolved to assess system risks with much greater granularity, and incorporating the dynamic risk management approach to risk assessment. This work is providing a fresh “risk lens” through which services can be understood and mitigations formulated to help alleviate the pressures under which many of them operate. The Committee recognises the hard work and dedication that has gone into the framework from individuals within the ICB and its partners.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 27 September 2024

Executive Lead: Maria Wogan, Chief of Strategy and Assurance

ICS Partner Lead: N/A

Report Author: Maria Wogan, Chief of Strategy and Assurance

Report to the: Board of the Integrated Care Board in Public

Item: 12.2 – System Risk Register and Board Assurance Framework (SRR/BAF)

Reason for report to the Board:
(a) NHSE requirement to report on system risks to Board
(b) power to approve the Risk Management Policy and Framework is reserved to the Board

1.0 Executive Summary

1.1 This report provides an overview of the System Risk Register/Board Assurance Framework (SRR/BAF) and ongoing risk management initiatives within the Integrated Care System (ICS). The SRR/BAF contains 12 strategic system risks. Notably, 10 out of 12 risks remain rated as HIGH, underscoring the need for focused mitigation strategies. Since the July Board meeting two risks have reduced in score:

BAF 003 – Urgent and Emergency Care – score reduced from 20 to 16 following system-wide risk assessment process
BAF 005 – System Transformation – score reduced from 20 to 12 following the delivery of the key mitigating actions: agreement of ICB transformation priorities, establishment of the system transformation team and place teams and introduction of the portfolio report.

1.2 Since the last Board meeting, further work has been undertaken on developing our approach to **dynamic risk management** in relation to the UEC risk and the emergent VCSE sustainability risk. Following discussion of both risks with Risk Leads and Non-Executive Directors/Councillors from system Trusts and Local Authorities at the Audit and Risk Assurance Committee on 26 July we are in the process of finalising the risk assessments and descriptions for full inclusion on the SRR/BAF. **The Pressure on Urgent and Emergency Care (UEC) Risk Assessment (BAF 003)** is informing the development of the system winter plan and Key Risk Indicators (KRIs) for the UEC risk are being baselined so that regular reporting on these can commence. The detail of the UEC risk will be reported to the System CEO Group on 19 September and the outcome of this meeting will be reported verbally at the Board. The emergent **VCSE risk** is due for a further system and VCSE discussion in October to refine the risk description and proposed KRIs before being included on the SRR/BAF.

1.3 A system risk workshop on **cyber security** is due to take place at the end of September/beginning of October and the outcome will be reported to the Audit and Risk Assurance Committee on 16 October and to Board in December.

1.4 The **climate change risk (BAF007)** was reviewed in detail at the Environmental Sustainability System Leadership Group meeting on 13 August. The Group looked at the risk in a more granular level of detail than is currently described on the BAF and the BAF will be updated to reflect the outcome of this review.

1.5 At the last Board meeting, a risk assessment on the **Provider Selection Regime** impact for our largest non-acute NHS contracts – community services, mental health and children's services was requested. The timing of this risk assessment is being aligned with the transformation work programme on these services.

1.6 **Committee assurance of system risks**: Since the last Board meeting, the Finance and Investment Committee, Primary Care Commissioning and Assurance Committee and Quality and Performance Committee have reviewed the SRR/BAF risks that they are responsible for and updates from these reviews are included in the reports from these Committees. The Audit and Risk Assurance Committee on 26 July has reviewed the full SRR/BAF and the ICB's Corporate Risk Register.

1.7 The Audit and Risk Assurance Committee has reviewed the ICB's **Risk Management Policy and Framework** (approval of this policy is a power reserved to the Board of the ICB). Amendments have been made to reflect recent developments in relation to risk appetite, dynamic risk management and KRIs and the Policy and Framework is attached for approval, as recommended by the Committee following a second review of document by the Committee Chair.

2.0 Recommendations

2.1 The Board is asked to **note** the SRR/BAF update including the progress with the more detailed risk assessments undertaken with partners for the UEC and VCSE risks and **agree** any additional actions or mitigations required.

2.2 The Board is asked to **approve** the Risk Management Policy and Framework appended to this paper as recommended by the Audit and Risk Assurance Committee.

3.0 Key Implications

Resourcing	✓
Equality / Health Inequalities	✓
Engagement	✓
Green Plan Commitments	✓
BAF Risk	✓

Summary of SRR/BAF Risks – maps across to all implications above

Ref	Risk	Current Score	Relevant reports on Sept Board agenda & future agendas
001	Recovery of Elective Services	20	Item 14 - Quality and Performance report
002	Developing suitable workforce	20	Item 14 – Quality and Performance Report, Item 15 Finance Report
003	Pressure on Urgent and Emergency Care (UEC) in the BLMK System -	16 (reduced from 20)	Item 11 – Winter Planning Report and Item 14 Quality and Performance Report
004	Widening inequalities	16	Item 11 Winter Planning Report,
005	System Transformation	12 (reduced from 20)	Future meeting Strategic Framework Portfolio Tool Report
006	Financial Sustainability & Underlying Financial Health	20	Item 15 – Finance Report

007	Climate Change	16	Subject of seminar on 15 November to refresh the system green plan
008	Population Growth	20	Item 8 – Health Services Strategy and Item 9 Infrastructure Strategy
009	Rising Cost of Living	16	Item 11 – Winter Planning Report
010	Partnership working	9	Item 18 – report from Health and Care Partnership, Item 13 report from Bedfordshire Care Alliance, , item 11 Winter Planning Report Future meeting - Portfolio report
011	Health literacy - Denny Review	16	Annual Progress Report to December Board
012	System Collaboration	6	Future meeting - Portfolio report

4.0 Report

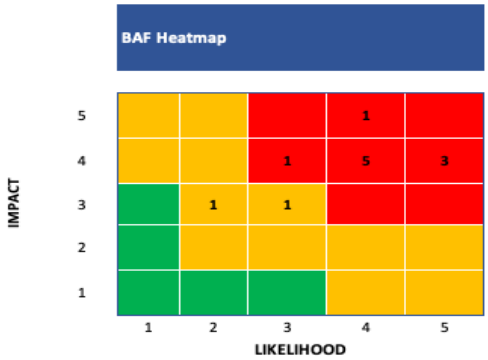
4.1 System Risk Register / Board Assurance Framework (SRR/BAF)

The SRR/BAF presently comprises 12 strategic system risks.

The graphics below illustrate that the risk profile of the ICB has been relatively unchanged for some time, which continues to suggest that external factors impacting these risks have not changed significantly. Two risks BAF 003 and BAF 005 have reduced in score since the last meeting. The ICB continues to focus attention on implementing necessary mitigation strategies to reduce these risks which is illustrated by the mapping of the risks to Board agenda items.

BLMK SYSTEM BOARD ASSURANCE FRAMEWORK

Risk Ref	Risk Title	Current Risk Rating	Trend
BAF0001	Recovery of Elective Services Risk	20	→
BAF0002	Developing suitable workforce	20	→
BAF0003	Pressure on Urgent and Emergency Care (UE	16	↓
BAF0004	Widening Inequalities	16	→
BAF0005	System Transformation	12	↓
BAF0006	Financi al	20	→
BAF0007	Climate Change	16	→
BAF0008	Population Growth	20	→
BAF0009	Rising Cost of Living	16	→
BAF0010	Partnership Working	9	→
BAF0011	Health literacy - Denny Review	16	→
BAF0012	System Collaboration	6	→



Risk Movement Over Time (23/24)

	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
BAF0001	20	20	20	20	20	20	20	20	20	20	20	20
BAF0002	20	20	20	20	20	20	20	20	20	20	20	20
BAF0003	20	20	20	20	20	20	20	20	20	20	20	16
BAF0004	16	16	16	16	16	16	16	16	16	16	16	16
BAF0005	20	20	20	20	20	20	20	20	20	20	20	12
BAF0006	20	20	20	20	20	20	20	20	20	20	20	20
BAF0007	16	16	16	16	16	16	16	16	16	16	16	16
BAF0008	20	20	20	20	20	20	20	20	20	20	20	20
BAF0009	16	16	16	16	16	16	16	16	16	16	16	16
BAF0010	9	9	9	9	9	9	9	9	9	9	9	9
BAF0011		16	16	16	16	16	16	16	16	16	16	16
BAF0012						6	6	6	6	6	6	6

4.2 The BAF template has transferred to excel and is developing to accommodate the dynamic risk management approach and KRIs. It will further evolve to reflect a more granular picture of where risk sits in the system and where responsibility for risk mitigations is held.

4.3 **Deep Dive Programme 2024/25**

A series of deep dives and dynamic risk assessments will continue across various areas at a pace that is subject to ICB and system capacity. The objective is to ensure that there is continuity to provide high-quality, resilient services and effectively respond to emerging challenges.

Ref	Risk	Action	Date
003	Pressure on UEC in BLMK system	Update and report to Audit and Risk Assurance Committee Regular oversight by System UEC Planning and Assurance Group	16/10/24 monthly
New	Cyber Security	Dynamic Risk Assessment Workshop	Late Sept/early Oct
New	VCSE Sustainability	Review at system/VCSE meeting	October 2024
New	Provider Selection Regime for Community and Mental Health Services	Dynamic Risk Assessment workshop	Jan-March 25
New	Benefits realisation from digital transformation	Dynamic Risk Assessment workshop	TBA
New	Estates Infrastructure	Dynamic Risk Assessment workshop	TBA

5.0 Next Steps

5.1 The SRR/BAF will be presented to:

- System CEO Group – 19 September – focus on UEC Dynamic Risk Assessment
- Part 2 - Audit & Risk Assurance Committee – 11th October 2024 including:
  - Final review of the UEC risk
  - Initial review of the cyber security risk

5.2 Risk management communications and training to be rolled out within the ICB over next 12 months.

List of appendices

Appendix A – System Risk Register/Board Assurance Framework
Appendix B – ICB Risk Management Policy and Framework – **for approval**

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 27 September 2024

Report Author: Shirley Pointer, Chair of Quality and Performance Committee

Report to the: Board of the Integrated Care Board in Public

Item: 14.1 **Alert, Advise and Assure Report to the Board of the Integrated Care Board**

Committee: Quality and Performance Committee

Recommendation: The Board are asked to **discuss** the issues raised by Quality and Performance Committee on 13 September 2024.

Key discussion points and matters to be escalated from the meeting.

ALERT: Matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the ICS strategy

- **None**

ADVISE: The Board of areas subject to on-going monitoring or development or where there is insufficient assurance

- **Bedfordshire Hospitals Trust (BHT) Patient Safety Incident –** In April and July 2024 BHFT experienced an intermittent issue with HbA1c blood test analysing machines at the Luton and Dunstable University Hospital laboratory which may have resulted in some patients receiving HbA1c results that were potentially higher than actual. HbA1c is a blood test that measures the average blood glucose levels of an individual. It is used to diagnose type 2 diabetes and prediabetes, as well as monitor blood glucose control in people with diabetes. Based on expert clinical advice regarding prioritisation, BHFT are currently contacting all those who had potential incorrect tests to give further details and offer a re-test as a precaution**.** The Committee noted the role of the ICB in providing system wide coordination and support, including with Primary Care colleagues to support retesting. The Committee discussed the quality assurance within pathology services and noted that recommendations for the investigation report would be discussed at a future Committee meeting. The Committee intend to undertake a deep dive on pathology services across BLMK in due course.

- **Elective waits –** work continues to reduce 65 week waits. Both Trusts have been written to by National Director of Elective Recovery, as the target date to address this was September 2024. Assurance was provided that all patients are clinically reviewed and prioritised accordingly. It was noted that BLMK is one of the few systems without an elective hub; we are asked as a system to consider this by national and regional teams.

- **Diagnostic waits –** there are a number of scanners out of action at both acute sites and some will not be re-instated for 3 months. In month 3, the ICB continues to be ranked as the lowest performing in region. This is being closely monitored by Executives across the system. The implementation of Community Diagnostic Centres (CDC) was reported, including delays at Lloyds Court due to issues with power supply. The decision not to fund a CDC in Luton adversely affects diagnostic wait times and exacerbates inequalities.

- **Severe Mental Illness (SMI) health checks Q1 delivery** – delivery is at 49.9% against a 57% target. There is ongoing work with primary care, mental health providers and VCSE outreach work to address this. There is targeted work with practices that have low uptake of SMI health checks including work to streamline those with learning disabilities (LD) and SMI and encouraging one health check visit for both LD and SMI.

ASSURE: Inform the Board where positive assurance has been received

- **Maternal deaths review at Bedfordshire Hospitals (BHT)** – The ICB's Chief Medical Director and Chief Nurse wrote to BHT regarding methodological issues regarding the review process and a response has been received which has provided assurance regarding the issues raised.

- **LMNS –** there will be a report to the next meeting to provide ongoing oversight of the work across the system, following a safety summit in September. The report will highlight areas of concern and good performance. A performance dashboard is being produced.

- **Health Services Strategy –** there has been wide engagement on the draft strategy across the system. It is a clinical strategy that highlights the challenges faced across the 2040 timeline which aligns with the Joint Forward Plan. There are six programmes of work identified through stakeholder analysis and population health data. Collaboratives are already established for some of these priority areas e.g. MHLDA, Cancer, LMNS, and there needs to be a refresh current groups or establish new groups to focus on Long-Term Conditions, Urgent and Emergency Care and fragile services. A Health and Care professional leadership group will be established to drive the work streams. SMART metrics for each programme will be developed following agreement from the Board and will be reported back in six months' time. Feedback noted that the Strategy covers a number of clinical perspectives, there was a clear steer to focus on prevention and that primary care estates needs capital investment. **The Committee endorsed the six programmes of work and recommend to the Board to approve.** The Committee noted that the strategy provided an important foundation to focusing work on developing our health services, but it was recognised that the next stage of developing the delivery plan would need to address the issue of prioritising the activities, people resource and finance to focus on the areas that deliver maximum impact for patients.

- **Inequalities update** – Inequalities funding was allocated to Place to decide what to spend money on locally and a small amount retained for system projects. The methodology of allocation of funding based on population health needs to be discussed further. Inequalities runs through all areas of health and care and health equity should be a key aim of the ICB with partner agreement. The Denny review recommendations have been incorporated in the health equity programme and actions have been included in the Learning Action Network (LAN) partnership which is an equal partnership with residents, health and care partners and is supported by the Institute Healthcare Improvement. The LAN is focusing on hypertension and using data to target specific populations. Other areas that have been prioritised are interpretation services and health equity work in Women's health. A detailed update on the Health Equity Programme will go to Board in Dec 2024.

- **Population health deep dive on working age adults** – The Committee welcomed the positive role of the Population Health Intelligence Unit in providing detailed analytics. Cancers and diseases of the circulatory system accounted for nearly half of all deaths in 2022. The largest cause of years lived in ill-health were musculoskeletal (MSK) and mental health (MH) which has been increasing since the pandemic. The consistent decrease in physical activity correlates to the increase of MSK presentations in primary care. Increased physical activity is proven to improve MSK issues and mental health. The requirement to link the data to actions and measure the impact was stressed, and this will focus the planned Board paper.

- **Patient Safety Incident Response Framework Update (PSIRF) –** large providers are rolling this out and examining how to undertake system reviews. The ICB is working with smaller providers e.g. hospices and 2 of the 3 hospice providers have provided evidence of their adoption of PSIRF. The ICB is working with other smaller providers to provide training and adoption of the PSIRF framework. There is not an obligation for GP practices to sign up to PSIRF at present, however, the ICB has been doing some PSIRF awareness training which has reached 400 clinicians in Bedfordshire and Luton and there are planned sessions for Milton Keynes. The ICB is working with NHSE Region and CQC to ensure

that what is being implemented meets the national framework. Oversight of the implementation of the policy will be through the established system quality safety groups. PSIRF is also discussed at Safeguarding group to avoid duplication and identified that the PSIRF investigation can be undertaken quickly, and some of the actions will be implemented before the safeguarding review is reported. The importance of learning from harm for the resident and the workforce was emphasised, and the need to draw evidence from all reviews.

- **Specialised Commissioning** – 59 specialised services were delegated to the six ICBs in the Eastern Region from 1 April 2024. On 1 April 2025 the Specialised Commissioning staff will be transferred by TUPE to BLMK as host ICB for the region. The specialised commissioning teams work across the region and undertake dedicated work with specific ICB's if there are issues in that geography. Governance is through Quality Safety Groups and System Quality Groups which will have a dedicated specialised commissioning item on the agenda and the Regional Joint Commissioning Consortium.

RISK: Advise the Board which risks were discussed, and any new risks identified

- **System Risk Register/BAF and Corporate Risk Register –** the three risks on the Corporate Risk Register and six on the System Risk Register were agreed as appropriate for the Committee to oversee. A dynamic risk approach has been undertaken by system partners for the Urgent and Emergency Care risk and it will be reported to the Audit and Risk Committee in October. It was recognised that the dynamic risk methodology was an appropriate approach, particularly for the risks where the mitigations do not change the overall risk score.

CELEBRATING SUCCESS: Share any practice, innovation or action that the Committee considers to be outstanding

- The Committee welcomed the clear intention of the Health Services Strategy to ensure that planning is underpinned by insights from population health data.

- The Chair commented on the very positive collaboration between the ICB, Bedford Borough Council and a housing partner to address health and housing in the design and development of a regeneration project in Bedford town centre.

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 27 September 2024

Executive Leads: Sarah Stanley, Chief Nursing Director and Maria Wogan, Chief of Strategy & Assurance

Report Author: Neve Patel, ICB Head of Performance

Report to the: Board of the Integrated Care Board in Public

Item: 14.2 - BLMK Quality and Performance Report – M3 – June 2024

Reason for report to the Board:
The Board should receive an update on the quality and performance of the system for which it is responsible.

1.0 Executive Summary

This paper provides an overview of key Quality and Performance challenges and successes. At the request of the Quality and Performance (Q&P) Committee, it includes an update on GP industrial action, elective long waits, diagnostic performance and Community Diagnostic Centre rollout, Serious Mental Illness health checks, and VCSE performance. A fuller report was considered by the ICB's Quality and Performance Committee on 13th September and this paper reflects the feedback the Committee gave.

2.0 Recommendation

2.1 The Board is asked to **review & comment** on the attached Report from the Q&P Committee. The Board will also have noted the Strategy Paper on the Board's agenda today reflecting our shifting approach to measurement in BLMK, informed by the Data Pyramid approach. This includes initial Strategic Outcome Measures and lead indicators for each of our Strategic Priorities.

3.0 Key Implications

Resourcing	✓
Equality / Health Inequalities	✓
Engagement	✓
Green Plan Commitments	✓
Board Assurance Framework	✓

System workforce, finance, estates, and digital resources impact all areas of performance and quality. Key risks are included within the report and described in the BAF. Inequalities are considered in all aspects of transformational work as a part of the quality agenda, using the Equalities Impact Assessment Process.

4.0 Report

4.1 Background

A performance dashboard is included as an appendix to this report, which focuses on narrative to explain changes in performance and associated action plans.

4.2 Key Performance Indicators

Primary, Community and Social Care – Responsible Body - Primary Care Delivery Group (for Primary Care only)

GP Collective Action *(Update)*

The ICB has been monitoring appointments in general practices in the context of 'GP collective action' and there has been no identifiable reduction of services. It is currently unknown how many practices are or plan to take action, or the type of action (with up to ten options of the kind of action practices could take). The ICB and Primary Care team will continue to review daily patient metrics to monitor variation, including GP appointments available, A&E arrivals, discharges and 4 hour waits, and NHS 11 calls.

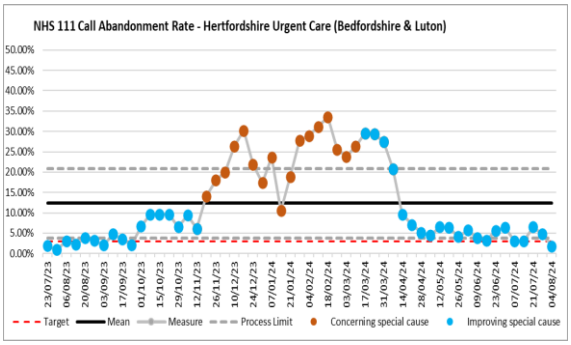
NHS App utilisation *(Update)* Place based variance: Luton

M4 has seen 53% of GP Patients aged 13+ registered for the NHS App across BLMK (60% BLMK aspiration by June 2025), with 356,629 logins, (one quarter of practices in BLMK are above the 60% threshold) with data showing that the 65+ age group are the most predominant users of the app. The table below shows the five practices with the highest and lowest logins per 1,000 list size. A new NHS App Task and Finish group is analysing options to drive up app usage to improve primary care access and empower patients to self-care by allowing them to view their own records, test results and order repeat prescriptions; the national aim is to encourage and drive-up usage of the NHS app to enable a single source solution for patients. The Group is also focusing on app promotion with community groups across BLMK, and lobbying for different languages to be available on the App. The ICB Board is taking at item on NHS App utilisation at its September 2024 meeting.

Top 5 Practices		Lowest 5 Practices	
Practice	Logins per 1,000 list size	Practice	Logins per 1,000 list size
Newport Pagnell Medical Centre (MK)	854.0	Malzeard Road Practice (L)	87.7
Watling Vale Medical Centre (MK)	670.7	Ashburnham Road Surgery (BBC)	89.3
Sandy Health Centre (CBC)	568.8	Neville Road Surgery (L)	106.9
Hilltops Medical Centre (MK)	519.4	Conway Medical Centre (L)	110.6
Walnut Tree Health Centre (MK)	517.9	Linden Road Surgery (BBC)	127.1

NHS 111 Calls Abandoned *(Update)* – Responsible Body – UEC Planning and Assurance Group / Place based variance: Bedfordshire Care Alliance

HUC (Bedfordshire provider) is on an improvement trajectory with a M3 abandonment rate of 5.06% (latest *published* data). Performance has since improved in August and is back under the 3% threshold. The National resilience support has now reduced to 10% of offered calls. At HUC the improvement Plan is being monitored by commissioners and NHSE IUC leads at monthly Performance Review Meetings. Recruitment of



additional call handlers is on track as well as productivity efficiencies. Commissioners and NHSE IUC team are currently assured that low call abandonment rates will be maintained through the winter period. DHU (MK provider) has an improved abandonment rate of 3.97% in M3 and has further improved in August to under the 3% threshold.

Community Waiting List *(Update)* **–** Responsible Body: CYP – Childrens Transformation Board; both Adults and CYP waiting lists are addressed at provider contract meetings. Place based variance: As below

Service	ELFT		CCS						CNWL	
	BLMK		BB		CBC		Luton		MK	
Jun-24	Total Waiting	% Over 18 Weeks	Total Waiting	% Over 18 Weeks	Total Waiting	% Over 18 Weeks	Total Waiting	% Over 18 Weeks	Total Waiting	% Over 18 Weeks
Adult's Services	3721	42.27%	214	26.64%	Figures to the left are for BB & CBC combined		797	13.55%	541	39.00%
Children's Services	657	74.58%	1069	53.98%	1454	52.06%	1702	51.47%	1740	54.37%

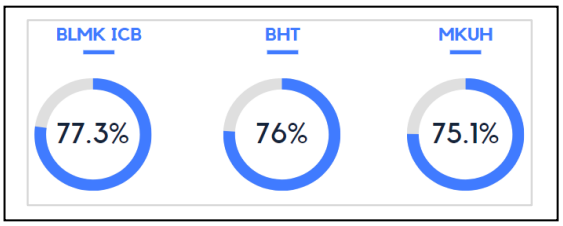
Patients Waiting Over 18 Weeks to start treatment

ELFT Adults – *decrease of 7.14%* over the last 3 months (1,694 to 1,573). Podiatry had the highest waits with 1,054 patients. A patient prioritised support pathway with a new criteria is in place, with telephone triage and face to face appointments. **Children –** *decrease* of 12.97% in same period; similarly, children's podiatry had the highest waits with 539 patients.

CCS Adults – 21.32% *increase in waits* over the last 3 months (from 136 to 165); the Adult Nutrition and Dietetic service had the highest waits with 105 patients. **Children –** *increase of 1.66%* in same period, highest waits within Community paediatrics continue. All long waiters are supported through online workshops and the earlier intervention team.

CNWL Adults – 14.92% decrease in waits over the last 3 months (from 248 to 211); podiatry services continue to be impacted due to staff AL and departmental vacancies. Daily triage of new referrals and prioritisation continues. **Children** – *increase of 14.25%* in the same period (828 to 946); highest waits within Community paediatrics with referrals continuing to rise and exceed demand; supporting actions include recruitment to vacant posts, ICB recurrent finding agreement from Sept. 2024, and planned weekend clinics.

A&E 4 Hour Waits *(Success)* - Responsible Body – the UEC planning and Assurance meeting / NHSE Constitution Measure / Operational Plan / SOF Metric (Improved – p6) / Place based variance: Milton Keynes Hospital.



In M4 (latest *published* data) BLMK ICB exceeded the national target of 76%, with 77.3%, securing first place in region. The ED cubicle at L&D was closed for a period due to the refurbishment; whilst these re-opened on the 2nd August, August performance will be impacted.

Virtual Ward *(Success)* **-** NHSE Operational Plan

System virtual ward bed occupancy has improved to 86% in June (latest published data). The ICB continues to rank among the highest in the country for the number of virtual ward (VW) beds per 100,000 population. This positive trend is attributed to ongoing expansion efforts in Bedfordshire and of particular note a Perfect week/Made event in Milton Keynes, where the awareness of Virtual ward

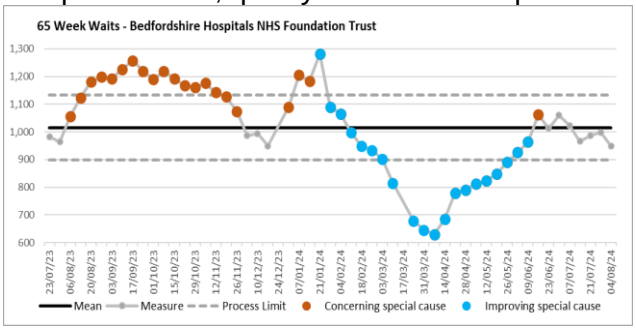
was raised within the Acute Hospital. However, there is a risk to the continuation of digital remote monitoring post-March 2024, pending the identification of recurrent funding.

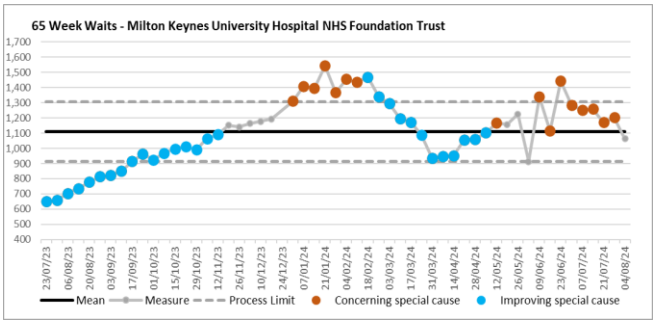
Long Waits – 78 and 65 weeks - (*Challenge)* - Responsible Body: Elective Leadership Group / NHSE Operational Plan / Place based variance: Milton Keynes Hospital.

The system continues work towards reducing long waits and at M3, the ICB has 98 78w waits (5/6 in region) and 2,209 65w waits (5/6 in region), placing the ICB 57% over our M3 operational plan. BHT are over plan by 192% with 1,070 patients waiting 65w weeks and MKUH are 17% above their plan with 1,288 patients.

NHSE continue to have oversight of MKUH through Tier 1 monitoring for elective care. MKUH are progressing recovery plans including the use of a vanguard theatre, PIFU and additional clinics. Waiting list validation is on-going with a revised plan due by the end of August. Insourcing and outsourcing have been operational from July which will start to impact performance. MKUH continue to experience challenge within Urology, Trauma & Orthopaedics and Ophthalmology which are being actively managed with teams. Capacity within gynaecology remains a challenge for BHT; additional clinics are in place; an additional consultant has been recruited starting mid-August and hysteroscopy specific outsourcing will be explored. Both trusts have signed up to NHS Emeritus which will support triage capacity.

The Quality and Performance Committee noted that BLMK are one of the only areas that do not have an Elective Care Hub and that the system needs to understand and consider the impact of this on patient care, quality of service and performance.





Diagnostic Waits *(Challenge)* - NHSE Constitution Measure / Operational Plan / SOF Metric / Place based variance: Bedfordshire Hospital Trust

In M3 *the ICB continues to be ranked as the lowest performing in region and nationally* against the 6-week standard due to the high volume of patients on the waiting list (39,089). 45.8% waited more than 6 weeks for their diagnostic test, against the system operational target of 15% (for 2024/25). Challenges include modality recruitment at both Trusts (NOUS / Audiology), increased demand from UEC and elective care and CDC implementation – see below. To support workforce, the system is progressing a bid for funding to secure ongoing SRO clinical leadership to the programme. The ICB workforce team are working with Trusts to develop a workforce strategy, including development of a strategic recruitment and retention plan.

Community Diagnostic Centre *(Update)* – NHSE Operational Plan

Community Diagnostic Centres (CDC) will help to achieve earlier diagnosis for patients through more direct access to a range of diagnostic tests. The Department of Health and Social Care have approved the following CDC centres; North Bedfordshire CDC Hub (Gilbert Hitchcock House), Milton Keynes CDC Spoke (Lloyds Court), Milton Keynes CDC Spoke (Whitehouse Health Centre). The

CDC Approval Panel did not approve the proposal for a CDC within Luton on the basis that an exact site location had not been confirmed.

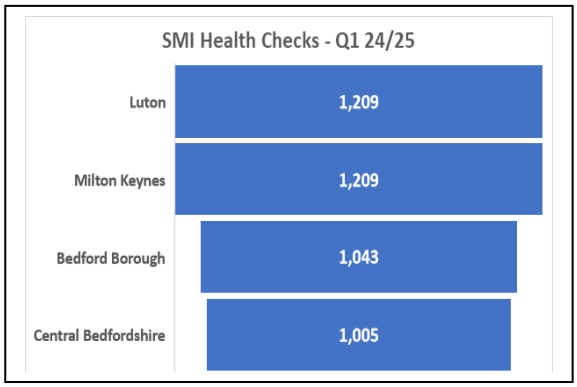
Milton Keynes - Lloyds Court CDC was due to open in March / April 2024, however due to on-going issues with the building (leakage / power requiring planning approval) this is now off track. To mitigate some of this, MKUH are undertaking a risk assessment to assess the feasibility of partially opening Lloyds Court so they can start seeing patients from October (current go live date), whilst remaining building issues are resolved.

Bedfordshire - The full Luton CDC business case remains in its current form until the capital and revenue funding opportunity is confirmed. The opening of the Bedford CDC remains on track for Aug/Sept 25. The ICB is supporting Trusts by identifying ISP capacity to aid recovery but may be constrained by the financial position and spare capacity is limited. Overall improvement will be monitored through strengthened diagnostic performance management through contract meetings and monthly deep dives within elective leadership meetings.

Cancer – 28 Day Faster Diagnosis (Update) – Responsible Body - BLMK Cancer Programme Board NHS Constitution Measure / NHSE Operational Plan / Place based variance: Milton Keynes Hospital

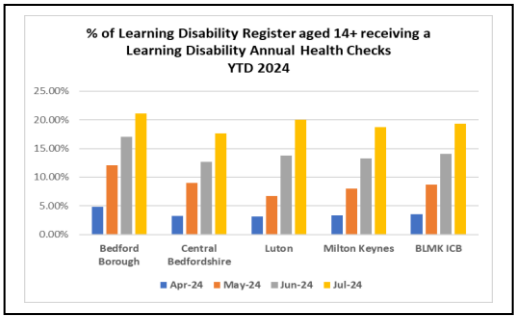
Cancer pathways continue to be increasingly complex and impacted by high referral volumes, delays, and diagnostic bottlenecks. The ICB is working toward the revised national target of *77% by March 2025*, with a good understanding of challenges and performance variation. At M3, the ICB achieved 72.23% which is 0.2% above the M3 plan. Focus remains on Gynaecology, Urology and Colorectal as the pathways contributing to the performance challenges.

Serious Mental Illness (SMI) Health Checks – Responsible Body - Mental Health Programme Board; underpinned by the BLMK MH Transformation (*Challenge)* - NHSE Operational Plan / Core20Plus5 / Place based variance: Central Bedfordshire



Over Q1, the ICB carried out 4,466 SMI checks, equating to 49.9%, against the 57% Q1 target (60% by March 2025). The number of patients on the SMI register has seen a significant increase between Q4 23/24 and Q1 24/25. The ICB is collaborating with GPs to identify and add eligible patients, conduct reviews, and create a video to help with recording. Outreach teams are also helping to identify patient groups. They are also working with primary care to understand the checks better; it is unclear whether checks have been done but not recorded correctly or if the patients have not been invited for them. There is a cohort of patients who sit on both the LD and SMI register who have an LD check but not an SMI check; practices are being supported to address this.

Learning Disability Health Checks *(Update)* - NHSE Operational Plan / Outcome Measure / SOF Metric / Place based variance: Central Bedfordshire



July / YTD shows achievement of 19% against the 25% target (75% cumulative target); this is an increase of 1.9% on the same time last year. The lowest performer at place was Central Bedfordshire with 17.6%. Luton saw the highest increase in checks in the last month with a 46% increase. Although the majority of checks take place within quarters 3 and 4, there is a work plan in place including reviewing records and sending invites to patients missing a health check. Evidence shows that patients with a recorded "reasonable adjustment record" on Sumary Care Records are more likely to attend health checks. In BLMK, 1 in 6 LD residents have this. ELFT are supporting GPs to improve their understanding and logging of reasonable adjustments records to encourge attendance.

Inappropriate Out Of Area placements / Bed Days – NHSE Operational Plan (OOA placements in 2024/25) / SOF Metric.

At M3, the ICB continues to be challenged with bed pressures requiring the need to purchase out of area (private sector) acute beds. The ICB is two patients over our OOA placement plan for June with 15, ranking 5/6 in region (this equates to 1,350 bed days against a regional average of 2,298). The MH delivery group (ICB, ELFT and CNWL) meet weekly and receive updates on bed activity and plans to mitigate; ELFT have agreed an exit strategy with the objective of reduction to 100% by December and 85% (optimal level) by 2026. To support this ambition, ELFT are currently purchasing 20 step-down beds with a plan to reduce to 10 by the end of October.

CYP Mental Health Access *(Challenge)* – Responsible Body: Overall leading on Transformation - Children & Maternity Transformation Board / - NHSE Operational Plan / Core20Plus5

BLMK is currently 12% below the M3 CYP mental health access target of 15,190, with achievement of 13,375.

(-12%). The primary challenge arises from a change in data definition; a cohort that were previously included within this metric are now longer able to be counted within the data flow; access has since seen a decline. There is a system recovery plan in place which feeds into the ICS Mental Health Delivery Group; actions include identifying missed opportunities to include data. Mental Health support teams are working with schools and have identified this as a potential area to improve data reporting to mitigate the access performance gap; implementation of all actions from the recovery plan are progressing through a task and finish group. Regional support in September to reviewing productivity across Mental Health services will support CAMHS transformation, increase access and enable learning from other ICB's.

Place Based Performance - Responsible Body: Bedfordshire Hospitals Trusts

In April and July 2024 BHFT experienced an intermittent issue with HbA1c blood test analysing machines at the Luton and Dunstable University Hospital laboratory which may have resulted in some patients receiving HbA1c results that were potentially higher than actual. HbA1c is a blood test that measures the average blood glucose levels of an individual. It is used to diagnose type 2 diabetes and prediabetes, as well as monitor blood glucose control in people with diabetes. Based on expert clinical advice regarding prioritisation, BHFT are currently contacting all those who had potential incorrect tests to give further details and offer a re-test as a precaution. Only HbA1c tests during certain days in April and July are affected by this issue. This incident is being managed internally by BHT and the ICB is providing system wide support around retesting through primary care. For further information on patient communications, see link to BHT website. The Quality and

Performance Committee noted the importance of ongoing ICB and system partner input into the investigatons into the incident.

4.3 Other Performance Updates

VCSE - The VCSE sector provide invaluable support to BLMK ICB by supporting health outcomes, enhancing patient experience, and providing advocacy and representation. **Children & Young People Services** - Continue to embed the principles of children's mental health 'I Thrive' approach to identify and support social and emotional wellbeing. Each Place have mental health and emotional wellbeing VCSE services locally (e.g., Stepping Stone, Relate (MK), Bedford Open Door, Sorted across Bedfordshire, and Tokko Youth space in Luton). **Mental Health Services** – Services for carers include: the Mental Health Online Carers Group, Befriending Service, Carer Link Workers, Carers in Bedfordshire SMI Nurse project; the Tibbs Foundation; Rethink – Physical health navigator working with people in Bedford Borough (20 people referred), see table (1) below; and the Memory Navigation Service – run by carers in Bedfordshire – supporting a combined 320 customers over Q1.

(1) Rethink outcome achievement - Q3&4	
Improved physical wellbeing	76.92%
Improved Mental wellbeing	76.92%
Improved self esteem	92.31%
Improved confidence	92.31%

Green Plan – Responsible Body - Environmental Sustainability System Leadership Group

The ICS and Trust Green Plan plans are undergoing a refresh, due for approval in March 2025. The ICB have made good progress toward reducing emissions including desflurane and acute trusts have saved 24.5% of Nitrous Oxide and N2O/O2 mix compared to the 19/20 baseline. Despite positive gains, BLMK still remains in the bottom quartile for both inhaler metrics with Primary Care working to accelerate the shift to lower-carbon inhalers through next year's prescribing incentive scheme.

BLMK Oversight Framework

BLMK ICB are currently at SOF Segmentation Level 2 (Flexible Support). Comparing August to July there have been 2 indicators that have improved from Amber to Green and 2 indicators deteriorated from to Red.

August metric movements across quartile ranges				
BHT	S124a Percentage of beds occupied by patient who no longer meet the criteria to reside	Amber to Green	⇧	
ICB	S127a A&E - percentage of patients managed within 4 hours	Amber to Green	⇧	See page 4 in report
BHT	S123a Adult general and acute type 1 bed occupancy (adjusted for void beds)	Amber to Red	⇩	
MKUH	S124a Percentage of beds occupied by patients who no longer meet the criteria to reside	Amber to Red	⇩	

The ICB has received its annual assessment letter from NHSE Region, and this was circulated separately to Board members. The overall rating of the ICB is expected from NHSE in September. A report on the annual assessment and the ICB's action plan in response will be presented to the September Board meeting.

Background reading

Appendix A BLMK ICB Dashboard
Appendix B NHS App Practice Level Usage Chart

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 27 September 2024

Report Author: Manjeet Gill, Chair of Finance and Investment Committee

Report to the: Board of the Integrated Care Board in Public

Item: 15.1 Alert, Advise and Assure Report to the Board of the Integrated Care Board

Committee: Finance and Investment Committee

Recommendation: The Board are asked to **discuss** the issues raised by Finance and Investment Committee on 6 September 2024.

Key discussion points and matters to be escalated from the meeting.
ALERT: Matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the ICS strategy
• **Financial sustainability** - Ensure adequate oversight of the risk of financial sustainability and adequate plans that deliver more recurrent schemes.
ADVISE: The Board of areas subject to on-going monitoring or development or where there is insufficient assurance
• **Finance report Month 4 ICB -** The ICB is reporting a £2.5m deficit year-to-date (YTD) (£1.2m in month 3) against a planned breakeven position. The deteriorating position relates mainly to continuing health care, delegated primary care and prescribing. During July the ICB prepared a recovery trajectory which was agreed with NHSE. This anticipated a growing deficit until September, reducing across the remainder of the year as mitigations took effect. The significant increases in cost pressures this month have exceeded the planned trajectory and a revised trajectory is being prepared which will seek mitigate this deteriorating position. • Due to the deteriorating position the ICB has strengthened it financial recovery measures. Recovery will be led by the Financial Improvement Group (FIG) chaired by the Chief Financial Officer. A new Investment Oversight Panel is now formed, meeting fortnightly and chaired by the CEO, it will scrutinise expenditure before commitments are made. • The ICB continues to forecast a breakeven financial position, but this is becoming significantly more challenging. • The ICB has appointed an independent innovation and transformation consultancy to investigate and support opportunities for efficiency and productivity. The appointed consultant is already working with Milton Keynes University Hospital. • **System financial report -** NHS organisations hosted within the system (Bedfordshire Hospitals and Milton Keynes University Hospital) are reporting a £9.1m deficit year to date against plan for income and expenditure. All organisations are forecasting breakeven against plan for the year. • The system has developed a system financial recovery trajectory, including the expected impact of specific interventions and actions. At Month 4 the ICS was £1m adverse to the target recovery trajectory. Further work is required to deliver mitigations and get back on track. • Regular meetings are taking place with system Directors of Finance, Chief Operating Officers and Workforce Directors to identify actions to mitigate the financial position. • **Contacting and Procurement –** the Committee were advised that there were two contracts that had not been signed with providers and that the national escalation deadline was week commencing 9 September. Negotiations were ongoing and it was hoped that these contracts could be agreed before the national escalation process was required.

- **Financial and Contracting Risk Registers –** operational and corporate risk registers for finance and contracting are reported to each meeting. Future reports will include more details on the risks, controls and mitigating actions.
- **Workforce deep dive –** a presentation on ICB and ICS workforce, staff survey and system working was provided. It was recognised that workforce was a significant proportion of the cost of providing health and care and was key to productivity. BLMK is one of three national exemplars for people digital which is expected to deliver 2% improved productivity.
  The BLMK People Board oversees six workstreams Primary Care Training Hub, Neighbourhoods, Workforce Information, Planning, Supply & Retention, Innovation & Education, Equality Diversity and Inclusion & Wellbeing, Leadership, Talent Management and Organisational Development.
  There had been growth in the workforce in BLMK and a deep dive on productivity was requested. This would provide information on the proportion of the workforce that was driven by regulatory requirements and national policy and would enable a measurement against activity to identify productivity.
  The introduction of new models of care, digitisation and dis-investment in low value activity would affect workforce modelling in the future, and having a flexible, diverse and well-trained workforce was key to ensuring efficient and effective care.

ASSURE: Inform the Board where positive assurance has been received

- **BLMK Community Musculoskeletal Services - Procurement commencement Gateway –** the Committee received a detailed report and presentation on the development of the procurement for musculoskeletal services since the Extra-Ordinary Board meeting in Private on 26 April 2024. The report included information on the process that has been followed, the key risks and mitigations and the next steps The Committee were assured on the process undertaken and how the issues raised by Board members had been responded to.

  The Committee agreed to approve the MSK Programme Board's recommendations to:

  a. **publish the Invitation To Tender (ITT) documents for the BLMK Community MSK Service on the basis there is no material difference to the business case agreed at ICB Board in April, and**
  b. **take the decision to award a contract at an extraordinary ICB Board meeting in February 2025.**
- **Contracting and Procurement**
  Integrated Urgent Care procurement had been considered by the Primary Care Commissioning and Assurance Committee (PCCAC) and it recommended to the Board to direct award to the current providers for two years until 30 September 2028 to enable the full integration of urgent and emergency services for our population**.** (see report from PCCAC on this agenda).
  The Committee has requested that the procurement pipeline report includes the value and duration of the contract, the commissioning approach and the expected impact on the strategic outcomes.

- **BLMK Infrastructure Strategy**
  The Board considered the draft BLMK Infrastructure Strategy at its meeting on 19 July 2024 which has been developed by the system Capital and Estates Oversight Group. Further work has been undertaken on the Infrastructure Strategy that follows the national guidance and focuses on the 330 healthcare properties in BLMK.

  The Strategy highlights the scale of investment needed in the estates and digital infrastructure within BLMK in order to i) maintain services, ii) to grow services in line with population growth and rising service demand, and iii) to achieve the system's environmental responsibilities. This amounts to a requirement of circa £3bn investment over the next ten years.

The Committee discussed the changes to models of care, digital advances and maximizing the use of assets, which affects the capital requirements for the future provision of healthcare.
The Committee endorsed the BLMK Infrastructure strategy and recommended it to the Board for approval (see item on this agenda).

RISK: Advise the Board which risks were discussed and any new risks identified

- **Financial risks –** given the month 4 position of the ICB and system and the need to take mitigating action to identify additional efficiencies, the financial risk register and BAF risk will be reviewed.

CELEBRATING SUCCESS: Share any practice, innovation or action that the Committee considers to be outstanding

- Positive feedback from region about engagement of partners including Workforce in financial efficiencies meetings

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 27 September 2024

Executive Lead: Dean Westcott, Chief Finance Officer

Report Author: Finance Department

Report to the: Board of the Integrated Care Board in Public

Item: 15.2 BLMK ICS Finance Report for Month 4 (July 2024)

Reason for report to the Board:
The Board should receive a finance update of the system for which it is responsible.

1.0 Executive Summary

1.1 This report sets out the 2024/25 BLMK ICS financial position as at 31st July (Month 4). The table below shows a summary of key financial metrics for NHS organisations hosted within the system.

	YTD Financials	Forecast Financials	YTD Efficiency	Forecast Efficiency	Agency Cap	CDEL
Bedfordshire Hospital NHS FT	R	G	R	G	R	R
Milton Keynes NHS FT	R	G	R	G	G	G
BLMK ICB	R	G	A	G		

1.2 NHS organisations hosted within the system are reporting a £9.1m deficit year to date against plan for income and expenditure, all organisations are forecasting break-even against plan for the year.

1.3 Without action, the system will deliver a year-end deficit. A range of actions and mitigations are already in place to recover the deficit. However, further system and organisational focused work across a range of areas to eliminate CIP gaps and mitigate emergent risks. The system has developed a system financial recovery trajectory, including the expected impact of specific interventions and actions. At Month 4 the ICS was £1m adverse to the target recovery trajectory. Further work is required to deliver mitigations and get back on target.

1.4 The system plan included a net unmitigated risk of £55.7m which remains at Month 4 reporting. There are new financial risks that have emerged since the plan submission – this includes: industrial action, enduring UEC pressures, investment required following recent CQC findings, and the premium costs required to support delivery of the 65ww performance target (Tier 1). These issues will need to be managed and successfully mitigated to deliver plan.

1.5 The system is overspent year to date against its capital allocation. This is largely driven by two schemes at Bedfordshire Hospitals, the Acute Services Block for which spend is ahead of plan, and the Bedford SDEC scheme for which funding has not yet been formally approved. Bedfordshire Hospitals is committed to managing its full year capital spend within the CDEL allocation given.

2.0 Recommendation

2.1 The members are asked to receive this report for **noting.**

3.0 Key Implications

Resourcing	✓
Equality / Health Inequalities	
Engagement	
Green Plan Commitments	✓

3.1 The finance plan reflects operational plans that include a focus on addressing the Green Plan Commitments and Health Inequalities.

3.2 The report includes content provided by partner organisations to describe their financial position.

4.0 Report

4.1 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, covering both revenue and capital. These organisations are:

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

4.2 Where NHS organisations provide services within BLMK, financial information is included within the report where available. The latest publicly available information on local authority finances for 2024/25 is provided in summary in Appendix A.

System NHS Income & Expenditure

4.3 The table below shows year to date and forecast expenditure for the organisations that are included in the BLMK financial control total. At month 4 year to date net expenditure is £9.1m higher than plan. All organisations are forecasting break-even at year end.

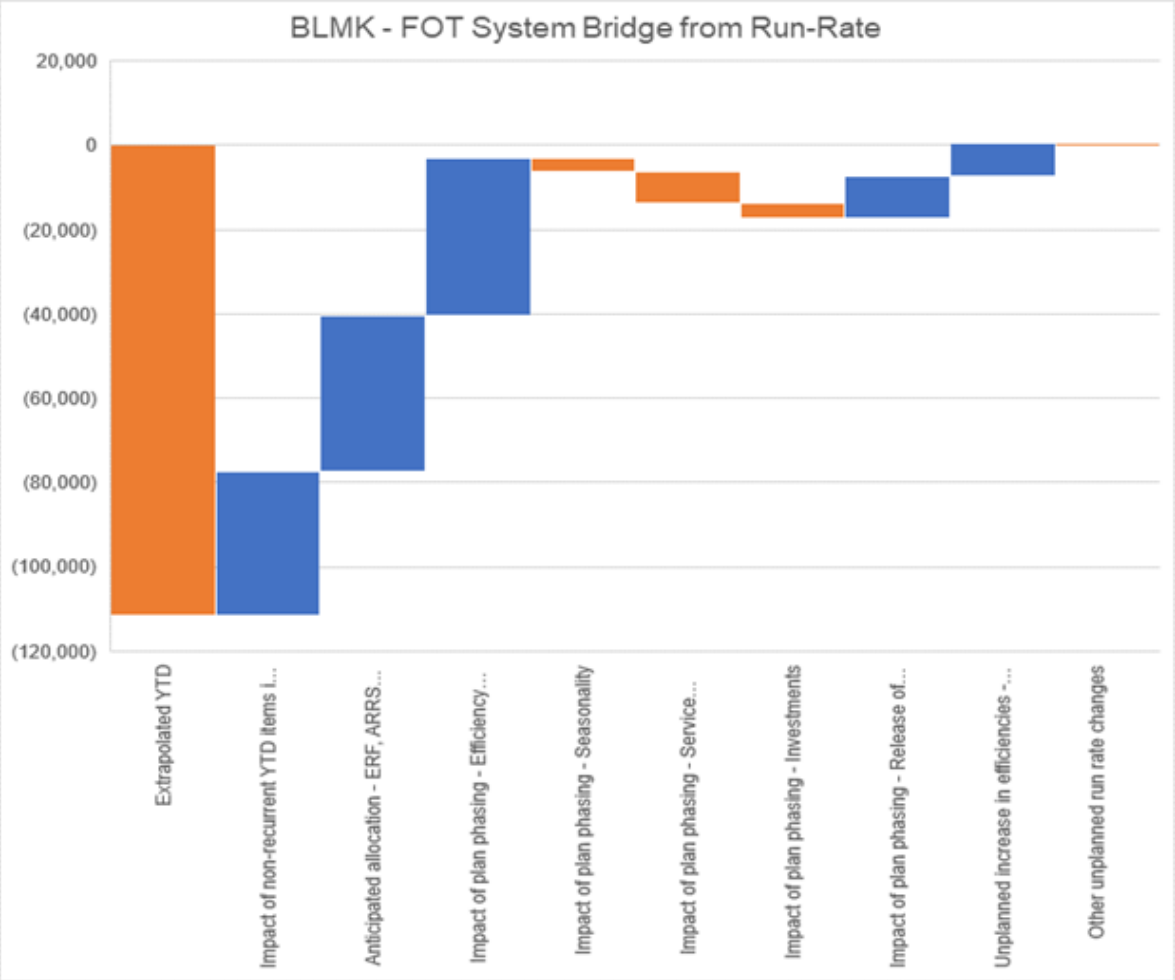
Surplus / (Deficit)	Year to Date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£m	£m	£m	£m	£m	£m
Bedfordshire Hospital NHS FT	(5.0)	(11.2)	(6.2)	0.0	0.0	0.0
Milton Keynes NHS FT	(3.8)	(4.3)	(0.4)	0.0	0.0	0.0
BLMK ICB	0.0	(2.5)	(2.5)	(0.0)	(0.0)	0.0
Intra ICS Organisations	**(8.8)**	**(18.0)**	**(9.1)**	**(0.0)**	**(0.0)**	**0.0**

The Month 4 system income and expenditure run-rate shows an adverse variance of £112m includes the following:

- £33m Low Value Activity (LVA) payment phasing
- £37m of expected allocations (ERF, ARRS, Pharmacy First)
- £37m of back-phased efficiency delivery phasing

The ICB run-rate deficit is c£65m but is skewed significantly by a range of issues including Elective Recovery Funding (ERF) and prepaid LVA. The Trust run-rate deficit is c£47m.

The bridge chart below shows consolidated key bridging movements from the current run-rate deficit to break-even. To deliver our financial plan, the system will need to deliver it's back-phased efficiency plan and deliver other unplanned mitigations.



Organisations and the system have a range of actions in place – however there is still an unidentified efficiency gap in plans, extant and emergent risks.

A forecast trajectory with key interventions / recovery actions and monthly targets between now and the end of the year was developed in July. At Month 4 the system is £1m adverse to its target recovery trajectory - we are seeking to find additional mitigations to deliver plan.

Intra ICS NHS Financial Performance:

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

Bedfordshire Hospitals NHS Foundation Trust

Income & Expenditure

The key points to note at Month 4 are:

- Reports a £6.2m deficit plan YTD and breakeven forecast:
- In Month 4 there was an improvement in run rate (£2.9m M3 vs £2.4m M4 adjusted financial performance). This was driven by improvements in agency spend (£2.3m M3 vs £1.6m M4) due to reduced contingency area usage and RMN spend, however RMN usage still is above plan.
- There was an overspend against plan on drugs (£6.3m M3 vs £6.9m M4) due to an increased spend in rheumatology and neurology due to NICE TAs.

BHFT Income & Expenditure	Year to Date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income	275,315	276,229	914	825,936	828,909	2,973
Pay	(175,926)	(181,164)	(5,238)	(518,202)	(521,175)	(2,973)
Non-Pay	(104,389)	(106,298)	(1,909)	(307,734)	(307,734)	0
SURPLUS / (DEFICIT)	**(5,000)**	**(11,233)**	**(6,233)**	**0**	**0**	**0**

Efficiency Plan Delivery

Currently behind on efficiencies, but recovery actions were started in Mid-May, areas are expected to show greater improvement going into Q2.

BHFT Efficiencies	Year to Date July 2024			Forecast		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
BHFT - Recurrent	11,072	7,752	(3,320)	33,210	33,210	0
BHFT - Non recurrent	7,192	4,410	(2,782)	21,581	21,581	0
Total	**18,264**	**12,162**	**(6,102)**	**54,791**	**54,791**	**0**

Capital Plan

BHFT Capital	Year to Date July 2024			Forecast		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Total Charge against Capital Allocation (before impact of IFRS16)	12,639	13,933	(1,294)	39,386	37,842	1,544
Total CDEL	18,410	20,417	(2,007)	57,359	61,068	(3,709)

The Trust has a challenging 24/25 capital plan, currently overspent due to spend on the Acute Services Block. Spend is being managed to remain within CDEL limit.

The Trust has submitted a business case for Bedford SDEC, the position above shows £6m forecast expenditure but the funding to offset this is not included in the plan as it is subject to approval by NHSE.

Milton Keynes University Hospital NHS Foundation Trust

Income & Expenditure:

- The Trust is reporting a deficit position of £4.3m (on a Control Total basis) to the end of the July which is £0.4m adverse to plan. This is an improvement of £0.5m on last month.
- Elective Recovery Fund (ERF) performance is currently above the 106% target, with income showing £5.6m above the national target as at M04 resulting in a favourable income variance to plan of £1.9m.
- The Trust has a challenging financial plan this year which includes a savings target of 6% (£23.8m). £3.6m has been achieved to date against a year-to-date plan of £7.9m.

MKUFT Income & Expenditure	Year to Date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income	127,325	130,809	3,484	383,143	383,143	0
Pay	(81,744)	(84,927)	(3,183)	(241,562)	(241,562)	0
Non-Pay	(49,420)	(50,161)	(741)	(141,581)	(141,581)	0
SURPLUS / (DEFICIT)	**(3,839)**	**(4,279)**	**(440)**	**0**	**0**	**0**

Efficiency Plan Delivery

£3.6m delivered against an annual target of £23.8m. This is an improvement on the run rate of £1.8m.

MKUH Efficiencies	Year to Date July 2024			Forecast		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
MKFT - Recurrent	3,092	3,605	513	9,275	23,474	14,199
MKFT - Non recurrent	4,848	53	(4,795)	14,547	348	(14,199)
Total	**7,940**	**3,658**	**(4,282)**	**23,822**	**23,822**	**0**

Capital Plan

£3.6m delivered against an annual target of £23.8m. This is an improvement on the run rate of £1.8m.

The YTD variance reflects the donated assets that are removed from CDEL. The forecast brings the spend in line with agreed CDEL allocation.

MKUH Capital	Year to Date July 2024			Forecast		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
Total Charge against Capital Allocation (before impact of IFRS16)	(990)	(731)	(259)	16,622	15,962	660
Total CDEL	1,722	1,496	226	35,287	34,627	660

Integrated Care Board

4.5 The ICB is reporting a £2.5m year to date adverse variance to plan and is forecasting break-even at year end.

4.6 The table below shows the status against the key financial performance indicators for the Year.

Performance Measure	YTD - Month 04			Forecast		
	Target	Actual	Variance	Target	Actual	Variance
Revenue Resource Limit	£722.1m	£724.5m	-£2.4m	£2,120.9m	£2,120.9m	£0.0m
Capital Resource Limit	£0.0m	£0.0m	£0.0m	£2.2m	£2.2m	£0.0m
MHIS Expenditure	£59.0m	£59.0m	£0.0m	£177.1m	£177.1m	£0.0m
Efficiency Savings	£8.3m	£8.0m	-£0.3m	£27.1m	£27.1m	£0.0m
BPPC	>95%	93%	-2%	>95%	95%	0%

Key: On target or better = <1% away from target = >1% away from target =

4.6 The financial position by commissioning programme as at Month 4 is set out in the table below:

PROGRAMME AREA	Year to Date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000
Total ICB Allocation	**788,983**	**788,983**	0	**2,309,221**	**2,309,221**	0
Acute Services	378,224	378,263	(39)	1,091,305	1,091,421	(116)
Mental Health Services	74,682	75,101	(420)	226,396	226,357	38
Better Care Fund	12,519	12,510	9	37,557	37,529	28
Other Community Services	52,606	52,715	(109)	159,341	159,050	291
Continuing Care Services	35,325	36,635	(1,310)	105,737	110,820	(5,084)
Primary Care Co-Commissioning	63,447	64,078	(631)	183,810	186,074	(2,264)
Pharmacy, Ophthalmic & Dental Co-Commissioni	31,398	31,432	(34)	92,711	92,511	200
Prescribing	52,692	54,309	(1,617)	159,402	163,666	(4,264)
Other Primary Care Services	10,207	10,420	(213)	31,874	31,841	33
Other Programme Services	66,924	66,924	0	188,331	188,331	0
Reserves	5,585	3,695	1,890	16,631	5,495	11,136
Total Commissioning Expenditure	**783,609**	**786,081**	**(2,473)**	**2,293,095**	**2,293,095**	**0**
Running Costs	**5,374**	**5,378**	**(3)**	**16,126**	**16,126**	**0**
SURPLUS / (DEFICIT)	**0**	**(2,476)**	**(2,476)**	**0**	**(0)**	**(0)**

4.7 The key points to note at month 4 are:

Income & Expenditure

The ICB is reporting a £2.5m deficit YTD (£1.2m in M3) against a planned breakeven position. The forecast assumes mitigations can be delivered to achieve a breakeven financial position by year end. The position as at Month 4 is set out in the table below:

- The ICB developed a system financial recovery trajectory in July including the expected impact of specific interventions and actions. At Month 4 the ICB is reporting a £2.5m overspend which is £0.7m adverse to its internal trajectory, reflecting the demand and cost related issues for delegated primary care, prescribing and CHC. Further work is taking place in August to update assumptions and reassess the trajectory.
- **Acute services,** the pressures relate to continued growth in demand for diabetes insulin pumps. At this stage of the year, it is assumed that ERF overperformance funding will be available to offset provider elective activity overperformance.
- Pressures in **mental health services** continue to relate to complex placement costs out of area or under S117 aftercare. The forecast has deteriorated in month due to several new high-cost packages. There is a challenging efficiency target to be delivered, which is also now phased in from Month 4.
- For **community services**, activity volumes in some community contracts for ophthalmic services and IVF continue to fluctuate, however expenditure is now expected to be over plan in these budget areas for the rest of the year. This is offset by benefits from underperformance for MSK services in Luton and a reduction in unplanned spot placements for discharge beds.
- The **continuing healthcare budget** has been rebased on last year's outturn. This month has seen a continued deterioration in the position which is £1.3m overspent YTD (£0.6m at M3). This overspend is driven by growth in cases and increases in package complexity together with inflationary pressures on package costs. These pressures are forecast to continue, the ICB is reporting a £5.1m overspend for the year.
- The **delegated primary care** overspend relates to emerging pressures from the primary care framework (formerly Universal Offer) due to increased activity as well as recognising the pressure on the GP delegated budget arising from the increase in GP list sizes at a rate significantly higher than the allocation growth – the cost pressure is estimated to be £1.4m in-year. The Additional Roles Reimbursement forecast overspend of £7.4m is offset by a reserve adjustment at year end as per guidance

issued by NHSE. Plans are being developed to mitigate the increased framework spend and manage costs within the delegated budget.

- **Prescribing** costs in May were higher than expected due to price inflation. The current month's position and forecast includes a material judgement when estimating levels of accruals for June and July. Due to April and May being higher than anticipated this has led to a reassessment of the forecast from last month's break-even position to a deficit of £4m. However, there is potential for efficiency benefits to exceed plan and partly mitigate the increased spend in prescribing.
- The ICB report now includes £66.9m YTD delegated budget for **specialised commissioning**. The previously reported emerging pressure has now been offset by the release of centrally held reserves. It is expected that NHSE will release the remaining reserve held back in year to offset any further cost pressures.

The forecast position assumes that the ICB will mitigate £5.8m of efficiency plans still under development (currently reported as a target within reserves), a £1.4m pressure in delegated primary care and £4.8m of further potential risks to deliver breakeven.

Efficiency Plan Delivery

- The ICB is reporting YTD delivery of £8.0m of its £27.1m efficiency programme.
- The ICB had included £6.6m of unidentified efficiencies in its plan. It is forecast that additional savings from medicines optimisation and Mental Health and LDA schemes will reduce unidentified efficiencies to £3.5m.

Team	Year to date M04			Forecast M12		
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Complex Care & Personalisation	626	626	0	1,179	1,179	0
Corporate / Finance	832	832	0	2,500	2,500	0
Digital	39	39	0	118	118	0
Elective Delivery	464	464	0	1,400	1,400	0
Estates	124	124	0	374	374	0
Medicines Optimisation	3,600	4,270	670	8,560	11,400	2,840
MH & LDA	521	308	(213)	1,583	1,822	239
Primary Care	598	598	0	2,446	2,446	0
Quality & Safeguarding	600	600	0	1,807	1,807	0
Workforce	154	148	(6)	480	476	(4)
Unidentified	734	0	(734)	6,613	3,538	(3,075)
Total Efficiencies	**8,292**	**8,009**	**(283)**	**27,060**	**27,060**	**0**

Risks to Delivery of Financial Plan

The current ICB position has improved since the plan was produced. £10.6m of net risk has been identified over and above the reported I&E position. This includes:

- £5.8m savings plans in development.
- £3.0m Prescribing cost and volume risks.
- £1.8m CHC cost and volume risks

There are further potential risks not quantified, these include:

- Impact of Industrial Action within primary care.
- Impact of new NICE TAs - therapeutics / high-cost drugs e.g., obesity drugs.
- Any adverse impact of specialist commissioning delegation.
- Impact of under delivery of efficiency plans.
- Impact of Management / Running Costs budgets and ability to contain within allocation.
- Potential ICB Redundancy / Restructuring costs associated with Phase 2 of the ICB Running Cost challenge.

All risks will need to be fully mitigated through the development of an efficiency / transformation pipeline overseen by FIG, non-recurrent mitigations, contractual management, slippage on investment, and additional controls on recruitment.

Capital Plan

The ICB has been allocated capital funding of £1.7m to support GPIT, primary care estates and corporate capital. A further £0.5m of the bonus funding has been transferred to the ICB allocation.

Inter ICS NHS Financial Performance:

4.8 Providers hosted outside the system, are reporting a year to date overspend of £5.6m and are forecasting a year end overspend of £3.2m.

Surplus / (Deficit)	Year to Date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£m	£m	£m	£m	£m	£m
CNWL	0.0	(0.4)	(0.4)	0.0	(0.5)	(0.5)
ELFT	0.0	(5.2)	(5.2)	0.0	(2.7)	(2.7)
CCS	0.0	0.0	0.0	0.0	0.0	0.0
Inter ICS Providers	**0.0**	**(5.6)**	**(5.6)**	**0.0**	**(3.2)**	**(3.2)**

4.9 The key drivers for the variances are (*provider commentary*):

Central & Northwest London NHS Foundation Trust (CNWL)

CNWL ended M4 with a deficit of £0.43m split to £0.31m for MK Mental Health and £0.11m for MK Community Health.

The main drivers of the overspend on MK Mental Health are complex placements and an increase in Psychiatric ICU cost driven by complexity and longer length of stay. Other pressures mostly arising from increased temporary staffing costs across community, CAMHS and In-patients services. Increased complexity in our inpatient wards have resulted in enhanced observation hence increased nursing staff costs.

In community services the key drivers are:

- Increased nursing cost in WICU, due to safer staffing workforce requirement in response to the unit acuity,
- Continuous increase community paediatrics demand
- Increase in continence service expenditure due to excess inflation.
- Increase in hearing aid devices cost driven by demand.

The overall Trust-wide position shows a YTD deficit position of £0.5m currently but forecast to achieve a breakeven position.

East London NHS Foundation Trust (ELFT)

As at month overall the Trust is reporting a deficit position of £10.7m year to date, which is £7.9m adverse to plan. The key drivers of this variance are:

- Staffing pressures on inpatient wards, due to patient acuity and enhanced observation requirements
- Agency costs, arising from difficulties in recruiting medical and nursing staff.
- Financial Viability (FV) slippage

- Usage of private sector beds continues to be high. This is currently offset by income, but if requirements do not reduce, this will create a financial pressure in future months.

The Trust is already undertaking a range of actions to control expenditure. A new 'Going Further, Going Together' Board has been established, chaired by the CEO, which will strengthen the oversight of expenditure. However, issues with discharging patients is generating a material risk to the financial position. The Trust is having to use Private Beds at a far higher level than forecast, and the costs will soon exceed the level of funding that has been made available from the ICS. Work is being undertaken with Local Health Economy partners to understand this, but at present there is little in the way of mitigations.

At Month 4 the Trust reports a £5.3m deficit position for Bedfordshire and Luton Services; the key variances are below:

- Bedford Adult MH Service is overspent by £1.6m year to date. This is driven by; medical pay (£0.1m YTD), Private Beds (£1.7m); Inpatient wards have high acuity patients and enhanced observational needs, though this is offset by underspends from vacancies in other areas.
- Luton Adult MH Service is overspent by £1.3m year to date. The position is driven by medical pay (£0.2m YTD) mainly due to temporary staffing agency premium; Inpatient services (£0.3m YTD), driven by high acuity patients in Crystal and Poplars wards and enhanced observational needs; Private Beds (£0.8m).
- Bedford Community Health Service is overspent £0.9m year to date. The main cost driver is pay which is overspent by £0.8m YTD mainly attributable to the Primary Care at Home teams where there is high agency usage, arising from increased activity levels and high vacancy levels.
- Primary Care is overspent by £1.2m year to date. The adverse variance is primarily driven by pay which is overspent by £1.2m YTD largely due to over established GP posts and temporary staff usage - medical bank and agency.

Cambridgeshire Community Services NHS Trust (CCS)

- The position above is Trust-wide as BLMK level data is not available.

Service Development Funding (SDF)

4.10 As a system, BLMK receives SDF funds during the year to support NHSE priorities linked to the NHS Long Term Plan. The table below shows the funding received to date and month 4 and commitments made against that funding. The uncommitted funds of £4.3m largely relate to new schemes which are currently being developed and agreed.

Programme	Total Allocations	Committed	Uncommitted
Primary Care	3,562	1,835	1,727
Mental Health	18,417	17,910	507
Ageing Well	1,327	1,323	4
CYP	927	927	0
Cancer	3,376	2,895	481
Diagnostics	4,943	4,943	0
LD & Autism	2,267	2,267	0
Maternity	1,536	1,533	3
Personalised Care	126	126	0
Prevention	1,355	732	623
Other SDF/Other pressures	1,939	1,004	935
TOTAL SDF	**39,775**	**35,495**	**4,280**

Workforce

4.11 A cap on agency spend has been introduced by NHS England. The maximum spend for BLMK is £26m. This is not applied to individual organisations, but the combined intra ICS NHS partners. The table below shows that at Month 4 year to date spend was £3.0m above the pro-rata cap. Forecast spend is £0.3m below the system cap.

Agency Spend	Year to Date			Forecast Outturn		
	Actual	Cap - pro rata	Variance	FOT	Cap - pro rata	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Bedfordshire Hospital NHS FT	8,561	5,938	(2,623)	20,397	17,815	(2,582)
Milton Keynes NHS FT	3,190	2,809	(382)	5,511	8,426	2,915
Total	**11,751**	**8,747**	**(3,004)**	**25,908**	**26,241**	**333**

4.12 The year-to-date variance is due to continued use of contingency areas, additional hours carried out to reduce elective backlogs and to cover for the junior doctor strike.

Appendix A – Financial Positions of Local Authorities

Additional details regarding the financial positions of Councils can be found at the source listed.

Bedford Borough Council

(Public Pack)Agenda Document for Executive, 11/09/2024 18:30 (bedford.gov.uk)

THE CURRENT POSITION

The Council reports to the Executive the Revenue and Capital Budget Trends at the end of each quarter. The financial position in respect of the revenue budget remains challenging, with a forecast overspend of £5.518 million as at 30 June 2024. The Council is committed to, and continues to work towards, a balanced budget by the end of the financial year.

The table below summarises the budgetary position relevant to each Directorate, with detailed information by Directorate:

Budget Forecast as at 30 June 2024	Current Budget	Forecast Outturn	Forecast Variance
	£ million	£ million	£ million
Adult Services	63.453	67.036	3.583
Children's Services	49.584	46.926	(2.658)
Chief Executives, Finance & Corporate Services	22.520	23.218	698
Environment	39.613	43.434	3.822
Public Health*	0.000	0.000	0.000
Operational Net Cost	**175.170**	**180.615**	**5.445**
Financing	-4.932	(4.859)	0.073
Total	**170.238**	**175.756**	**5.518**

* Public Health is funded from a ringfenced grant and, therefore, any under or overspend is transferred to a separate Reserve

Revenue Budget – Mitigation of Pressures

Mitigating actions have already been taken by Directorates to respond to the forecast overspend and these are identified above. In addition, there are a number of actions that are being taken across the Council to mitigate the overspend including:

- reviewing all available budgets and releasing any which are likely to be underspent;
- review of use of agency staff across the Authority with a view to reducing the use of agency staff and where appropriate moving agency staff into permanent roles;
- review of one-off projects;
- ceasing all non-essential spend in supplies, stationery, subscriptions and other discretionary budgets;)
- a review of the profile of the capital programme is underway including the impact on cashflow and borrowing in the revenue account.

Savings related to these actions are being forecast in the relevant service as identified.

Further consideration is being given to identify actions to bring the budget in line by the end of the financial year that mitigate the impact on front line services, in consultation with Portfolio Holders.

Central Bedfordshire Council

21.1 Revenue Budget Monitoring Q1.pdf (azeusconvene.com)

Executive Summary

1. The forecast position after reflecting release of Contingency is a balanced budget.

2. Chief Executive, Resources and Corporate costs are forecast to be on budget.

3. Children's Services forecast £0.7M overspend. This is due to £0.5M Children in Care (CiC) Placements and £0.2M SEND Enhance Education Health and Care plan (EHCP) Writers.

4. Adult Social Care and Housing General Fund forecast £0.9M overspend. Mainly due to increased demand and placement costs against Nursing, Residential placements, and Learning disabilities.

5. Place and Communities forecast £2.3M overspend. This is mainly due to £2.1M Environment and £0.9M Development Infrastructure overspend, offset by savings in Business Investment and Client & Development. The Environment overspend is mainly due to waste collection, increased tonnage, and Household Waste Recycling Centre (HWRC) increased costs. Development Infrastructure overspend is driven by a reduction in Planning Income.

6. Public Health is on budget.

7. The table below details the full year variances by directorate:

Table 1

Directorate	Year to Date - June			Full Year		
	Budget £m	Actuals £m	Variance £m	Budget £m	Forecast Outturn £m	Variance £m
Chief Executive's	0.8	0.8	(0.0)	3.1	3.1	0.0
Resources	8.1	7.5	(0.6)	31.0	31.0	(0.0)
Corporate Costs	3.5	3.5	(0.0)	14.1	14.1	0.0
Children's Services	16.8	17.6	0.8	67.2	67.9	0.7
SCHH	24.6	23.3	(1.3)	98.3	99.2	0.9
Place and Communities	12.9	13.5	0.6	51.7	54.0	2.3
Public Health	(0.0)	(0.2)	(0.2)	0.0	0.0	0.0
Total Excl Landlord Business (HRA)	**66.7**	**65.9**	**(0.8)**	**265.3**	**269.3**	**3.9**
Contingency / Reserves					(3.9)	(3.9)
Full Year Forecast Outturn	**66.7**	**65.9**	**(0.8)**	**265.3**	**265.4**	**0.0**

Luton Borough Council

Document.ashx (luton.gov.uk)

2024-25 Q1 Revenue and Capital Monitoring Report

The first quarter of the Council's budget monitoring is still showing budget pressures which have continued from last year. The combined challenges from the ongoing delivery of budgeted savings, high levels of demand for services and costs pressures is proving to be a challenge given the cost of living crisis.

The continued budget pressures mainly in demand led services have huge impact on Local Government finance in general and the financial position of Luton Borough Council in particular. This position is not unique to Luton but systemic throughout Local Government, with increasing numbers of council's having to issue Section 114 Notices. The next spending review will take place by end of October which should indicate the level of funding for local government and also the distribution to councils hard hit in areas such as social care and homelessness. According to the Institute for Fiscal Studies Luton has the 2nd lowest level of public funding in the country relative to need.

The deficit in core services is significant and the impact from additional demands for services across Adult Care Services due to demographic growth in older people, mental health and transitions from Children's Services and long-term support for disabled people under 65. Whilst the government grants like social care grant and market sustainability & improvement fund (MSIF) have increased, the MSIF Workforce fund has reduced for this financial year. Despite receipt of these additional grants, the growth, inflation, and staffing pay award requirements for this financial year are putting a considerable above budget financial pressure on ASC service.

Reducing the number of households in temporary accommodation remains a key priority for the Housing service. During the past year the service has seen an increase in homelessness demand which led to the rise in duties to accommodate under homelessness statute. This developed into an increase in high-cost spot purchased

accommodation, the charges for which are mostly unrecoverable and borne by the Council. The Housing Market is increasingly competitive and this, coupled with cost-of-living pressures, mean that more households are unable to make their own way in the market. The greatest impact is felt by lower income and larger households – rents are rising and there is a corresponding increase in the rise in S.21 notices due to landlords raising rent or selling. This means that access to housing in the private sector to prevent, relieve and discharge homelessness duty is also reduced.

At Q1 the overall General Fund projected net revenue outturn position is £7.4m (Table 1 below) overspend against its £167.3m approved revenue budget. The gross core service deficit before the delivery of DRP savings (£4.9m), application of corporate items and release of contingency amounted to £12.4m. This overall overspend position is largely due the following:

• £1m forecast overspend in Supported Living Accommodation Costs due to increase in number of vulnerable residents requiring additional support in addition to the accommodation costs.
• £0.6m forecast overspend in Children, families and Education services. However the forecast overspend in Children's transport budgets amounts to 1.219m which is mainly in SEN transport including Post 16 out of borough SEN college transport.
• £2.635m overall forecast overspend in Adult Social Care services mainly in the purchased care service as a result of a combination of growth from transition placements and increases in home care and residential care.
• £3.309m forecast overspend in Housing mainly due to an increase in the number of Bed and Breakfast and nightly paid accommodations.
• Inclusive Economy reported an overall small forecast underspend of £20k due to staffing costs underspend across services. However, there are areas of concern which require close monitoring such as Corporate Landlord service contracts and service charges; income form Investment properties; Refuse & Cleansing vehicles costs of hire and repairs & maintenance.
• Despite the delivery of Deficit Recovery Plan savings of £4.984m, it is a huge challenge to achieve the position of a balanced, affordable and sustainable budget at year end. Growth of £3.8m has already been incorporated in this budget but the increasing budget pressures in the areas mentioned above are worsening the overall outturn position. There is an immediate need to make every effort to contain any overspend within budget and not to commit any unfunded growth or costs in order to avoid potential use of reserves in the future. It is necessary to consider the impact of a newly elected government with a pledge to bring economic stability through curbing public funding. The Chancellor has announced her acceptance of the pay uplifts for public sector workers which may impact of pay settlements for local government which would have a significant adverse impact on the Medium Term Financial Plan.

Executive is recommended to:

(i) Note the forecast net overspend of £7.4m and a gross core overspend of £12.4m reported at the first Quarter's monitoring for the current year.

(ii) Note the current forecast overspends at Q1 for the Public Health £391k, Housing Revenue an underspend of £488k and Schools budgets overspend being reported in Q1 is £0.339m which is mainly due to HNB demand pressures.

(iii) Note the 2024/25 adjusted Capital Programme of £184.701m: £122.556m for General Fund and £62.146m for HRA. At Q1, forecasted expenditure is £188.476m based on responses received, of which : £126.330m is General Fund and £62.146m is for HRA resulting in a cumulative projected overspend of £3.775m.

(iv) Note the urgent need for the full delivery of the savings initiatives identified as part

of the deficit recovery plan and transformation program in order to return the general fund to a balanced position by the end of the year and to improve the prospects for the 2025/26 Budget.

vi) Endorse the management action to deliver the deficit recovery plan (including 2024/25 and 2025/26 savings targets as approved by Full Council) at pace and scale in order to achieve an affordable and sustainable budget and prioritise the financial recovery plan as an integral part of the transformation programme.

(vii) Endorse the recommendation that the Corporate Management Team in conjunction with the S151 officer to implement urgent actions which include restricting non-essential expenditures and also applying cash limited budget in areas of overspend.

These spending controls are to remain in place for the foreseeable future until the financial position has improved and there is no need to draw down on reserves to balance the budget and the expenditure brought back within the budget approved by Council.

Milton Keynes Council

2024-25 P3 Forecast Outturn Report.pdf (moderngov.co.uk)

This report sets out the 2024/25 quarter 1 (QTR) forecast outturn for the General Fund (GFRA); Dedicated Schools Grant (DSG); Housing Revenue Account (HRA) and Capital Programme; based upon income and expenditure as at 30 June 2024.

- General Fund Services are currently forecasting an overspend of £10.082m which has partially been offset by £3.266m of one-off funding to give a net overspend of £6.816m. The overspend is mainly due to high-cost external residential placements in Children Services.
- The Housing Revenue Account (HRA) forecast outturn at P3 is an underspend of (£0.124m), which will be offset by an increase in the planned level of Revenue Contribution to Capital (RCCO).
- Public Health budget is forecasting a contribution to the Public Health reserve of £0.035m.
- The Dedicated Schools Grant (DSG) is forecasting an improved position with an estimated surplus carry forward £7.759m rather than estimated budgeted surplus of £6.500m.
- The Capital Programme is reporting an overspend of £1.545m, of which £0.218m is planned to slip to later years, leaving an in-year overspend of £1.327m

The table below shows the forecast outturn position by service area and the key variations against budget.

Table 1 – General Fund Revenue Account (GFRA) Summary

General Fund High Level Revenue Summary	P3 Position			
	2024/25 Full Year Budget	Outturn	Variance	% variance
Service	**£m's**	**£m's**	**£m's**	**%**
Adult Social Care	111.918	112.035	0.117	0.1%
Public Health	12.861	12.861	0.000	0.0%
Children's Services	61.117	71.642	10.525	17.2%
Customer and Community	9.036	8.785	(0.251)	-2.8%
Planning and Placemaking	(1.331)	(1.361)	(0.030)	2.3%
Environment & Property	74.649	74.381	(0.268)	-0.4%
Resources - Retained MKC	6.351	6.116	(0.235)	-3.7%
Resources - Shared Services	0.134	0.134	0.000	0.0%
Law & Governance	2.713	2.656	(0.057)	-2.1%
Corporate Codes & Debt Financing	17.260	14.275	(2.985)	-17.3%
Assets Management	(26.030)	(26.030)	0.000	0.0%
General Fund Requirement	**268.678**	**275.494**	**6.816**	
Total Financing	**(268.678)**	**(268.678)**	**0.000**	
Net Surplus / Deficit	**0.000**	**6.816**	**6.816**	

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 27 September 2024

Report Author: Alison Borrett, Chair of Primary Care Commissioning and Assurance Committee

Report to the: Board of the Integrated Care Board in Public

Item: 16 Alert, Advise, Assure Report and Integrated Urgent Care Contract Approval to the Board of the Integrated Care Board

Committee: Primary Care Commissioning and Assurance Committee

Recommendations:

1. The Board are asked to discuss the issues raised by the Primary Care Commissioning and Assurance Committee on 16 August 2024.
2. **The Board is asked to approve a direct award in accordance with the provider selection regime to both HUC and DHU for a further three years until 30 September 2028 to enable the full integration of urgent and emergency services for our population.**

Key discussion points and matters to be escalated from the meeting.

ALERT: Matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the ICS strategy

- **Strategic Outline Case for the reprocurement of Integrated Urgent Care in BLMK:** As discussed at the ICB Board seminar in June 2024, the Integrated Urgent Care (IUC) contracts in BLMK will expire on 30th September 2025. The contracts are provided by HUC (Bedfordshire & Luton) and DHU (Milton Keynes). IUC would be recognised by residents as the 111 service and GP Out of Hours.

The services and contracts in scope of the decision are as follows:

Contracts:	**Contracts are being reviewed now because they are due to end on 30th September 2025.**
Luton & Beds Integrated Urgent Care (IUC) (Includes 111, Clinical Assessment Service and GP Out of Hours)	The HUC IUC contract for Bedfordshire expired on the 31st March 2024. The ICB issued a Direct Award extension to the contract of 18 months to the 30th September 2025.
Milton Keynes NHS111	The DHU 111 contract for Milton Keynes expired on the 31st March 2022. The ICB issued a Direct Award extension to the contract of 2 years to the 31st March 2024. The ICB issued a further Direct Award extension of 18 months to the 30th September 2025.
Milton Keynes Integrated Urgent Care and Clinical Assessment Service and the Urgent Treatment Centre	The DHU UTC & IUC CAS contract for Milton Keynes initial term expired on the 31st March 2024. The ICB has taken up an 18-month extension option to the 30th September 2025.

The importance of integrated urgent care services was recognised during the committee's discussions. The critical connectivity to the quality of in-hours GP practices and community pharmacy services was understood. On-going effective communication will be prioritised to ensure residents are aware of the 24/7 primary care offer and the options were discussed including supported self-care, Pharmacy First, the use of the NHS App, to reduce the year on year increasing demands for same day primary and urgent care services.

The benefit of service and contract stability for Integrated Urgent Care was emphasised in the context of the delivery of current service transformation and efficiency workstreams. The aim is to enhance the integration of services and improve the overall resident

experience through collaboration with all providers who are delivering effective urgent care.
BLMK ICB is working closely with Hertfordshire, West Essex ICB, and Cambridge and Peterborough ICB on the productivity and transformation and wish to align respective contracts up until 2028. This collaborative transformation work is a key reason for recommending a contract extension until 2028. The three ICBs have agreed a collective plan to ensure provider stability.

The recommended contract extension would include an annual negotiation process with the IUC providers to address any necessary national policy adjustments.

In considering the two options available (Open Market Procurement and Direct Award) the PCCAC considered the risks of each, this is summarised in Appendix A.

PCCAC agreed to recommend to the ICB Board to approve a direct award in accordance with the provider selection regime to both HUC and DHU for a further three years until 30th September 2028.

The Board is asked to approve a direct award in accordance with the provider selection regime to both HUC and DHU for a further three years until 30 September 2028 to enable the full integration of urgent and emergency services for our population.

ADVISE: The Board of areas subject to on-going monitoring or development or where there is insufficient assurance

- **Lessons Learned:** a review took place in July following closure of Wenlock Street Surgery and Goldington Road Surgery. The purpose was to understand early warning signs, and to identify how the process of terminating a General Medical Services or Alternative Medical Services contract can be improved in the future. A summary of themes will be presented to the Committee in October 2024.
- **Delegation of Public Health Section 7a Services[1]:** Now to take effect in April 2026. Preparation in hand to ensure successful delegation. A timetable for delegation will be agreed with NHSE and the neighbouring ICBs.
- **Clinical waste collection services procurement:** BLMK ICB is party to the consortium procurement for clinical waste collection. The procurement is being undertaken for 24 ICBs nationally, 5 of which are in the EoE Region. A Regional Project Board has been established which is managing the procurement process and timelines. The Committee to be sighted on cost efficiencies once known.
- **Dental Contracts:** It was noted that several providers require early repayment mid-year, and six providers were delivering less than half of their contracted activity. The ICB are supporting dental contractors to align their contracts to what they can realistically deliver, and there is an opportunity to rebase contracts starting in April 2025. Despite ongoing challenges, debt for 2023/2024 has decreased by over £1.3 million, and the number of Units of Dental Activity (UDAs) delivered has increased by 170,000, while undelivered UDAs have decreased by 25,000, though still high at 167,779.
- **Primary Care Finance**: £2.5 million year-to-date overspend as of month 4 with a projected £6 million budget pressure by year-end, primarily due to increased prescribing costs. The ICB faces significant financial risks from rising prescription volumes, particularly diabetes drugs, inflation, and growing patient lists. The ICB has instigated financial recovery to mitigate these pressures. A backdated pay award for doctors will be processed in September. There is a need for close monitoring and action to align with the financial plan.

[1] Section 7A services refer to public health services which are commissioned by NHS England such as immunisation and screening programmes, as well as health care for people in prisons and secure units and some services for the armed forces.

ASSURE: Inform the Board where positive assurance has been received

- **Whaddon Medical Centre, Milton Keynes** boundary extension to include Eaton Leys, enabling the surgery to pick up housing development growth and supporting patients with greater level of choice.
- **Dental Capacity:** 28 practices have achieved over 100% (up to 110%) UDAs on mandatory services on their 2024/24 contracts and will receive over performance payments totalling £359,754.83.
- **BLMK Primary Care Access Programme (Fuller):** Significant growth in personalised care roles, including care coordinators and social prescribing link workers, within primary care networks since 2019. Focus is now on evaluating the impact on patient care and reducing workload through new metrics, dashboards, and case studies. Collaboration with institutions like the University of Cambridge and the Kings Fund aims to further evaluate these roles' effectiveness. Ongoing engagement include bespoke conferences and facilitated integration with broader healthcare initiatives.
- **Service Relocations and Upgrades:** The De Parys Group (DPG) has successfully relocated patient services to the Enhanced Services Centre. Plans to relocate King Street Practice to Kempston Health Centre by the end of September are progressing well. The new facilities will improve patient experience. The plans for reconfiguring space at Queens Park Health Centre are also progressing. Building work has been completed on Cranfield Surgery and a relocation date will be confirmed shortly.

RISK: Advise the Board which risks were discussed and any new risks identified

- **GP Collective Action:** Commenced on 1st August following a British Medical Association (BMA) ballot. NHSE have requested situation reports to help manage the impact and the ICB is handling this action through Emergency Preparedness.
- **Escalation of Risks:** Primary Care risks are regularly reviewed and escalated as necessary. Progress on mitigations are revisited at all future Committee meetings.

CELEBRATING SUCCESS: Share any practice, innovation or action that the Committee considers to be outstanding

- **Measles Collaboration:** Due to higher levels of measles in certain areas, particularly Milton Keynes and Bedford, a "measles cell" was quickly established, involving a broad range of stakeholders with leadership from primary care. The response, which included targeted actions in schools and Traveller sites, was effective in stabilising the situation. The meetings have been reduced in frequency due to the current stability, but the group remains ready to respond to future outbreaks. The Committee commended the collaborative, strong teamwork across various sectors, highlighting the quick mobilisation and effective leadership during the measles response.
- **Community Pharmacy Integration – Pharmacy First Service:** Pharmacy First service encompasses various services such as minor illness referrals, urgent medicine, and contraception services. Significant progress has been made by the Head of Community Pharmacy Integration Lead, who developed a "Pharmacy First" toolkit available online, providing practical resources for pharmacies and surgeries. Additionally, 24 PCN based webinars have been organised to better integrate pharmacy into primary care, leading to a notable increase in pharmacy consultations and contributing to recovering access to primary care.

Appendix A

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Options of when to use a competitive process	Key Features	Benefits	Disbenefit / Risks
OPTION 1: Complete a competitive procurement process now for service go live in Oct 2025	• Run a competitive procurement process and award to one or more providers ready for services to go live on 1st Oct 2025	• Opportunity to invite innovation from new providers	• Feasibility of delivery – limited window of time to complete significant work which would utilise more resource than alternative options • System partners may not support a short-term response to complex problems, and a potential change in provider/s • Workforce – retired GPs may choose not to work with new provider/systems (as happened in C&P) • Market appetite – BLMK have not conducted any engagement with the market, so appetite is unknown • Viability of HUC if C&P and BLMK award to another provider following a competitive process
OPTION 3: Direct award until Oct 2028 **RECOMMENDED OPTION**	• Extend the current IUC contract for 3 years • Run a competitive procurement process for IUC and UTC services at the same time as Herts & WE	• Align with Herts & WE IUC contract end dates to give opportunity for joint/aligned procurement strategy • Gives time to understand the impact of – Primary Care Access Recovery Plan & Urgent and Emergency Care Recovery Plans and Community Services review/ procurement • Enables the review of out of hospital services & design better integration • Potential to have greater interest from the market / greater competition and greater efficiency	• There may be delays to implementing the Primary Care Access Recovery Plan & UEC Recovery Plans and Community Services review/ procurement. • There may not be appetite from the market

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date of meeting: 27 September 2024

Executive Lead: Martha Roberts, Chief People Officer

ICS Partner Lead: N/A

Report Authors: Martha Roberts, Chief People Officer & Lynelle Hales, Managing Director of Specialised Commissioning for the East of England Region

Report to the: Board of the Integrated Care Board in Public

Item: 17 Specialist Commissioning Team Transfer from NHS England into BLMK

Reason for report to the Board: The purpose of this paper is to provide assurance regarding the transfer under Transfer of Undertakings (Protection of Employment)(TUPE) Regulations/Cabinet Office Statement of Practice of 40 - 60 NHSE staff on 1 April 2025 to BLMK ICB as part of the delegation of Specialist Commissioning (Spec Comm) Services. All necessary steps are being taken to safely transfer colleagues. The Board is asked to note the increase of the headcount of the ICB as an employer from 347 wte to c. 400 people, approximately 17% increase.

1.0 Executive Summary

1.1 Board members can be assured that all relevant stakeholders are being engaged appropriately, that there is sufficient BLMK managerial oversight and specialist resources are being provided to the project to address strategic and practical challenges to enable a successful transfer. The NHSE Spec Comm team have been, and will continue to be, supported, and welcomed into BLMK over the next months until their planned transfer on 1st April 2025.

2.0 Recommendations

2.1 The Board members are asked to note the report as an update on the progress and proposed transfer of staff as this is a significant addition to the ICB's workforce and responsibilities.

3.0 Key Implications

Resourcing	X
Equality / Health Inequalities	X
Engagement	X
Green Plan Commitments	X
BAF Risks	X

3.1 Only identified moderate potential implications.

3.2 Resourcing for this project is adequate both in terms of the qualified and experienced members of the implementation team and the financial settlement funding temporary additional roles in the ICB to support the transfer. The transfer of commissioning to ICBs is overseen by the East of England Joint Commissioning Consortium (JCC).

3.3 Individual staff members will have personal interviews to assess any equalities and health inequalities that may impact them on transfer.

3.4 All relevant stakeholders have been engaged and consulted with and engagement with NHSE and EoE ICB colleagues continues as part of the project plan.

3.7 No implications identifiedfor the Green Plan commitments.

4.0 Report

4.1 Introduction

4.1.1 At the NHS England (NHSE) Board meeting on the 7 December 2023 it was agreed that the delegation of Specialised Commissioning (Spec Comm) to ICBs in England would be supported. NHSE proposed that subject to proper assurance, BLMK ICB would host the delegated East Region Spec Comm team on behalf of all six ICBs in East Region. BLMK Board supported that proposition.

4.1.2 Staff in NHSE East supporting the commissioning of those delegated services will be transferred to BLMK ICB, subject to consultation, on 1st April 2025.

4.1.3 NHSE will retain responsibility for commissioning specialised services which were not suitable and/or ready for delegation, including all highly specialised services.

4.1.4 Regardless of delegation status, NHSE will remain the accountable commissioner for the entire portfolio of specialised services and maintain responsibility for setting consistent national standards, services specifications, and clinical access policies.

4.2 Delegation agreement

4.2.1 The delegation agreement for specialised services builds on the agreements put in place for already successfully delegated primary care services.

4.3 Current Position

4.3.1 BLMK ICB appointed a Managing Director (MD) to undertake leadership of the hosted delegated service who commenced May 2024. A Head of Transformation has been appointed and will commence in post from 23 September 2024. A senior finance lead role will transfer from NHSE with the team. BLMK has an agreement in place with NHSE that no decisions on changes to the staffing group will be enacted without the express agreement of BLMK management for the six months prior to the transfer date.

4.4 Finance

A recurrent cost allocation to cover all staff moving to BLMK ICB will be transferred from NHSE. Separate one-off costs, for example purchasing laptops and phones are being agreed with the ICB IT team and NHSE. This does not impact the 30% RCA reduction.

4.5 Risk Management

Identified risks are managed by the Joint Commissioning Consortium (JCC)

5.0 Next Steps

The HR transfer implementation plan, organisational development plan and workforce development work is ongoing to support a safe and compassionate transfer of staff.

List of appendices

Appendix A - Human Resources implementation plan

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 27 September 2024

Executive Lead: Maria Wogan, Chief of Strategy and Assurance

ICS Partner Lead: N/A

Report Author: Michelle Evans-Riches, Head of Governance

Report to the: Board of the Integrated Care Board in Public

Item: 19- Corporate governance Report – Including amendments to the Constitution of the ICB

Reason for report to the Board: The Board is required to agree its Constitution and request NHSE Approval of any changes. The Board is responsible for the approval of the Governance Handbook and any amendments made to it.

1.0 Executive Summary

1.1 NHS England has issued guidance and a revised model Constitution for ICBs. The amendments include:

- the appointment of a Senior Non-Executive Member.
  Alison Borrett was appointed as Senior Independent Director which has the same responsibilities but a different title by the Board in March 2024. It is proposed that Alison continues in this role with the new role title until 1 April 2026 as previously agreed.
- Deputy Chair – this is a new vacant role and it is recommended that Manjeet Gill is appointed to this role until 29 August 2025 when her current term of office as a NEM comes to an end.
- to reflect the maximum term of office for the Chair as 6 years. The changes to the constitution are summarised in the table at 4.1

1.2 The guidance also requires a lead to be appointed for Safeguarding (all ages) including looked after children and care leavers and it is recommended that this is the Chief Nursing Director.

1.3 Following the Board's decision to dissolve the Working with People and Communities Committee - on 19 July 2024, it is recommended that the Quality and Performance Committee be delegated the authority for the approval of arrangements for statutory consultation and / or engagement in relation to proposed service change in the Scheme of Reservation and Delegation (SORD).

1.4 The use of the Corporate Seal on documentation is reported to the Board as is good practice.

2.0 Recommendations

The Board is asked to:

2.1 **agree** the proposed amendments to the ICB's Constitution and request NHS England for approval.

2.2 agree that the role of Senior Independent Director will now be known as Senior Non-Executive Member and that Alison Borrett will continue in this role until 1 April 2026

2.3 **agree** the appointment of Manjeet Gill as the Deputy Chair of the ICB Board until 29 August 2025.

2.4 **agree** the Chief Nursing Director as the Board's Lead for Safeguarding (all ages) including looked after children and care leavers and the Governance Handbook Decisions and functions (Appendix Q) is updated accordingly;

2.5 **agree** that the Quality and Performance Committee be delegated the authority for the approval of arrangements for statutory consultation and / or engagement in relation to proposed service change and the Scheme of Reservation and Delegation be amended accordingly.

2.6 **note** the use of the ICB's seal, as detailed in the report.

3.0 Key Implications

Resourcing	✓
Equality / Health Inequalities	
Engagement	
Green Plan Commitments	
BAF Risk 004	✓

3.1 There are no implications relating to resourcing or Green Plan commitments a result of this report.

4.0 Report

4.1 NHS England has issued guidance for the revision of ICB's Constitution and a revised model constitution. The main changes and the actions and amendments to the Constitution are detailed below:

Change requirement	Amendments/Action
Making one of the non-executive board members, but not the Audit Committee chair, also the Deputy Chair of the board	Constitution paragraphs 2.2.3, 3.4 as follows 2.2.3 (f) Four non-executive members (one of which, but not the Audit Committee Chair, will be appointed Deputy Chair; and one of which, who may be the Deputy Chair or the Audit Committee Chair, will be appointed the Senior Non-Executive Member). 3.4 Deputy Chair and Senior Non-executive Member 3.4.1 The Deputy Chair is to be appointed from amongst the non-executive members by the board subject to the approval of the Chair. 3.4.2. No individual shall hold the position of Chair of the Audit Committee and Deputy Chair at the same time. **The Chair has recommended Manjeet Gill be appointed as the Deputy Chair of the Board of the ICB until 29 August 2025- when her current term of office as a NEM expires.**

ICBs should make one of their non-executive board members the Senior Non-executive Member to support the NHS England Regional Director in the appraisal of the Chair and their compliance with the Fit and Proper Person Test, and to act as a sounding board for the Chair and if necessary to mediate between the Chair and other board members. The Senior Non-Executive Member may, unless they are the Audit Committee chair, be the Deputy Chair	Constitution paragraphs 2.2.3, 3.4.3 as follows: 2.2.3 (f) Four non-executive members (one of which, but not the Audit Committee Chair, will be appointed Deputy Chair[18]; and one of which, who may be the Deputy Chair or the Audit Committee Chair, will be appointed the Senior Non-Executive Member). **Alison Borrett was appointed the Senior Independent Director by the Board on 22 March 2024 until 1 April 2026– the role will be re-titled Senior Non-Executive Member.**
Ensuring that the Chair's period of office is expressed clearly as a maximum rather than a fixed term, recognising that interim Chair appointments (approved by the Secretary of State) may be necessary	Constitution updated paragraph 3.3.4 as follows: 3.3.4 The term of office for the Chair will be a maximum of six years and the total number of terms a Chair may serve is two terms.
Updating the reference to procurement rules to take account of the introduction of the Provider Selection Regime	Already included in paragraph 7.4.2 and 7.4.3 as follows: 7.4.3 7.4.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime. The ICB will comply with the requirements of the NHS Provider Selection Regime including: a) Complying with existing procurement rules until the provider selection regime comes into effect. b) Establishing and using the appropriate decision-making arrangements to ensure procurements are robust and comprehensive, whilst maintaining proportionality. c) Applying the required criteria in evaluation and decision-making regarding provision of clinical services to ensure services procured demonstrate the best combination of benefits to the population, patients and the taxpayer. d) Establishing clear record-keeping protocols and ensuring appropriate transparency in decision-making to enable scrutiny of decisions. e) Securing services in a way which reduces health inequalities and promotes social value. f) Ensuring that procurement activities support service sustainability and are consistent with the integration and collaboration agenda of the ICB.

	g) Undertaking procurement activities to ensure high levels of quality of care both for the present and into the future through the use of innovation.
Removing the clauses related to the establishment of ICBs	Removed - reference paragraphs 1.5.2, 3.14 deleted
A small number of cross-references to other legislation	Incorporated as per Model Constitution References as follows: Paragraph 1.4.7f section 14Z4 (public involvement and consultation) Paragraph 7.3.8 amended as follows: 7.3.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years (the "Joint Forward Plan"). The plan will, in particular: h) describe the health services for which the ICB proposes to make arrangements in the exercise of its functions i) explain how the ICB proposes to discharge its duties under sections 14Z34 to 14Z45 (general duties of integrated care boards) and sections 223GB and 223N (financial duties) j) set out any steps that the ICB proposes to take to implement the BLMK joint local health and care strategy k) set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25 l) set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

	Appendix 1 Definitions of Terms Used in Constitution Amendment: **Area:** The geographical area that the ICB has responsibility for, as defined in clause 1.3 of this Constitution. Additions **Forward Plan Condition -** The 'Forward Plan Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance. **Level of Services Provided Condition -** The 'Level of Services Provided Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Compliant with the duty under section 14Z49 of the Act to keep under review the skills, knowledge and experience of the board	Paragraph 2.2.5 refers – no change
The conflicts of interest policy takes account of the introduction of the Provider Selection Regime and early findings on the management of conflicts of interest	This will be included in the review of the policy when the national guidance is issued. The Board at the meeting on 19 July 2024 agreed to extend the review date of the policy by six months to end of December 2024
Recognise the options related to the flexibility to delegate ICB functions to, or jointly exercise them with, other public bodies	Paragraph 1.7.3 (d) Scheme of Delegation – no change: "Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS Trust, NHS Foundation Trust, local authority, combined authority or any other prescribed body: or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act."

Portfolios of board members give board level executive leadership on care for specific population groups as has been articulated in th Guidance on Executive Lead Roles in ICB.	Additional requirement for Executive lead role for care leavers and this has been added to the Governance Handbook Decisions and functions delegated by the Board to individual Board members and employees including Groups (Appendix Q) as follows: **Chief Nursing Director:** **Safeguarding (all age) including looked after children and <u>care leavers</u>;**
Appendix 2 Standing Orders	Amendment to Chair of Meeting: .4.2.2 If the Chair is absent or is disqualified from participating by a conflict of interest, the Deputy Chair shall preside over meetings in the Chair's stead. 4.2.3 If both the Chair and Deputy Chair are absent or disqualified from participating by a conflict of interest the assembled members may to appoint a temporary Deputy for the purpose of chairing the meeting. In section regarding Quorum, addition of: 4.7.2 c A nominated deputy permitted in accordance with standing order 4.5 will not count towards quorum for meetings of the board.

4.1.1 The revised Constitution is in the reading room for members to refer to which incorporates the amendments above. For convenience of process, the proposed amendment to the quoracy of the Board from 50% to nine members, as agreed at the meeting on 19 July 2024, has been included in the revision enclosed.

4.1.2 The Board is required to agree the Constitution and request approval from NHS England to the proposed revisions.

4.2 **Delegation of approval of statutory consultation and engagement**

At the Board meeting on 19 July 2024, it was agreed that the Working with People and Communities Committee would be dissolved and the statutory requirements to involve would be overseen by the Quality and Performance Committee and amend the Governance Handbook accordingly. It is therefore recommended that the Quality and Performance Committee be delegated the authority for the approval of arrangements for statutory consultation and / or engagement in relation to proposed service change and the SORD be amended accordingly.

4.3 **ICB Seal**

In accordance with the ICB's Constitution the Board the ICB's official seal has been used in the following instances:

a) Deed of Indemnity between the ICB and Newport Pagnell Medical Centre Confidentiality agreement between Milton Keynes City Council and ICB (as part of licence to occupy)

b) S75 agreement between ICB and Luton Council.

5.0 Next Steps

- Submit revised Constitution to NHSE for approval.
- Update constitution once NHSE approval received.
- Update governance handbook once Board approval given.
- Communicate appointment of Senior Non-Executive Member and Deputy Chair to stakeholders and update website.

List of documents in the reading room

Appendix A – Constitution

Background reading

None for this report.