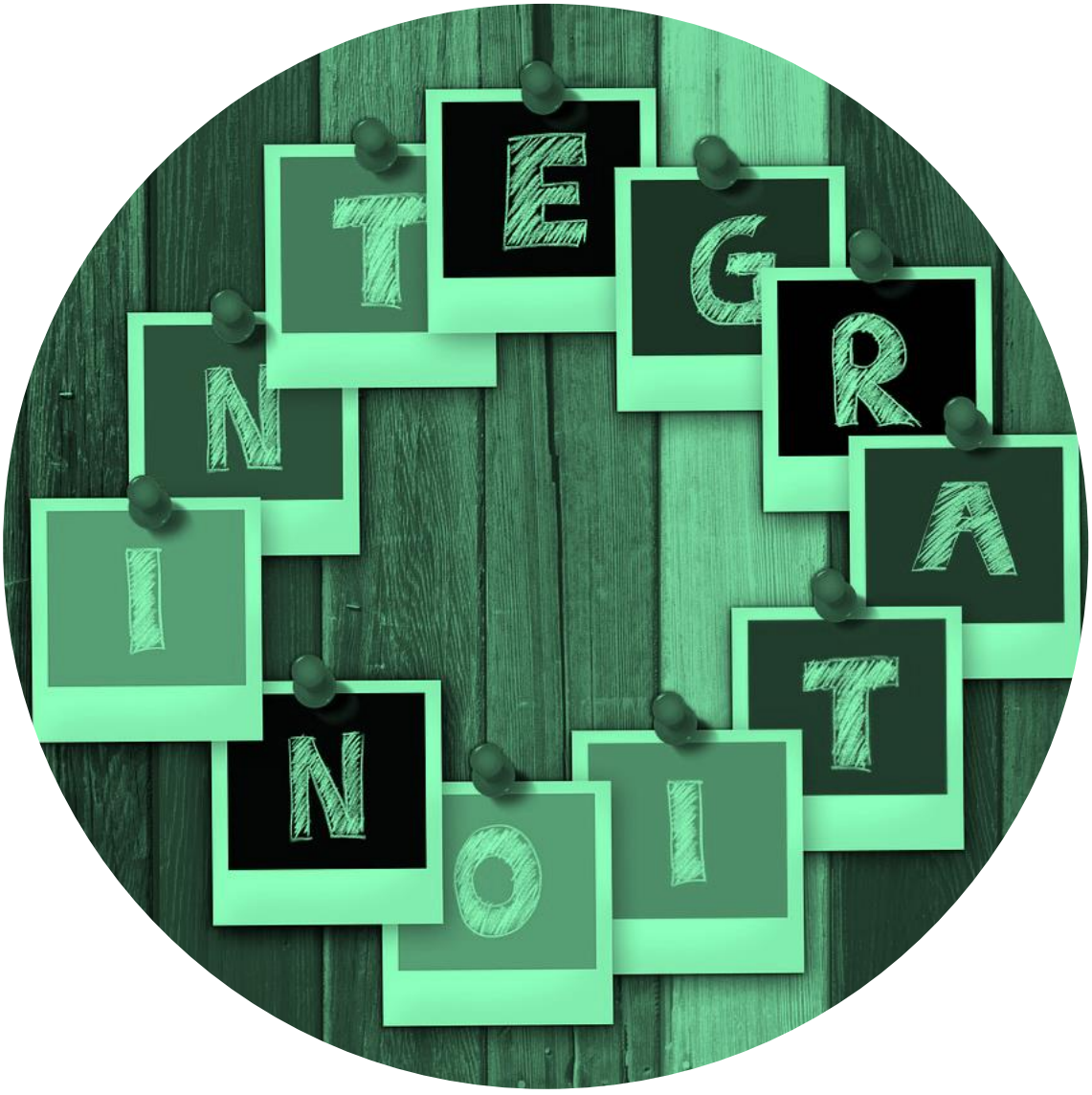
This folder contains background reading for the following agenda items:

Health institutions anchors: maximising potential through integrated care systems

An action plan for BLMK ICS



CLES
the national organisation
for local economies

Contents

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Summary

The purpose of our economy should be to generate good lives and wellbeing for all, not simply growth. People and communities everywhere should be given the opportunity to participate in economic activity and they should be entitled to a fair share of the proceeds.

With the introduction of the Integrated Care System (ICS) structure in England, and the ambition for these new health systems to contribute to social and economic development, the NHS's role as series of key anchor institutions has never been more important.

Anchor institutions are organisations that have presence and heft within the local economy, generating positive impacts for people and place. Anchors can exert sizable influence by using their spending power, employment capacity, and their real assets such as facilities and land, to affect the economic, social and environmental wellbeing of the localities they operate within.

This action plan for Bedfordshire, Luton and Milton Keynes ICS should provide food for thought in terms of how it can work to build a more inclusive economy. With a particular focus on its large provider trusts and local authority partners, it details the way in which the ICS could cultivate its place-based assets and harness its power as series of anchor institutions to develop the local economy from within.

From the insights we have gathered as part of this research, as well as CLES's wider portfolio of work, the action plan makes six key recommendation that are summarised as follows.

1. Redefine the ICS's ambitions around economic growth and agree a comprehensive measurement framework

The ICS has five strategic priorities. Economic growth is the fourth priority and this should be finessed to clarify that the ICS is not agnostic about the kind of economic growth that it intends to support. Going forward, the ICS's strategic intentions could be adapted to include a commitment to anchor principles and to the ICS using its power as a series of anchor institutions to drive inclusive economic activity and address population health needs in the process. In this, there should be a commitment to using the combined power of its place-based assets – namely public expenditure (procurement), employment and its estates to promote and elevate the grass roots economy. The action plan proposes a number of metrics that the ICS could deploy to track the progression of inclusive social and economic development across its geographical footprint.

2. Enable SMEs and other forms of progressive local enterprise to play a greater role in the BLMK economy

In line with the vision set out in action one, the ICS should look to develop a commitment across is partners to use spending as a mechanism to grow and develop the grass roots economy. Key to this commitment is integrating procurement data into economic development practice as has been pioneered in places such Fife and Carmarthenshire. This would involve a number of steps and actions, which we outline in detail in the full action plan below.

3. Agree a unified approach to securing additional social value during tendering activity

The emergence of BLMK ICS is an opportunity to review applications of social value across the patch, particularly in relation to the process for securing additional social value during tendering exercises. Social value weighing has been enthusiastically taken up by many local authorities who are using this opportunity leverage real social, economic and environmental benefit for local people. Building on this approach, partners could look to agree weighting targets for their tendering exercises. Moreover, thought should be given to the nature of the social value outcomes that are being sought across the patch. In particular, these should be tailored towards payment of the living wage and providing employment opportunities for people in areas of deprivation – including work experience for young people.

4. Explore how BLMK could work with other ICSs across England to establish social licensing for NHS Supply Chain

For many consumables, NHS Supply Chain will always provide the price and reliability that the NHS needs to deliver its services efficiently and effectively. Nevertheless, with a view to help meet net zero, and its wider ambitions as an anchor, BLMK could take the lead here and ultimately look to work with the other 41 ICS leaders to lobby the Department of Health to consider a form of social licensing for NHS Supply Chain – to guarantee certain social, economic and environmental returns.

5. Target skills development and employment opportunities towards people and communities who need them the most

To help alleviate poverty, deprivation and health inequalities within BLMK, it is within the gift of all anchors to consider how their employment and skills development opportunities could be targeted towards those who are most in need. The BLMK People Board could the take the lead here and could look to scale and amplify the activity to date across the geographical footprint. It could begin by seeking to build a greater understanding of the local provision of employment support for those furthest from the labour market and then look to develop a programme that would remove as many barriers to employment as possible. Ultimately, the ICS could then look to extend the programme beyond its NHS partners. This recommendation would involve a number of steps that are again outlined in detail in the full action plan below.

6. Deepen the function of land usage and disposal across the ICS footprint

The upcoming refresh of the ICS estates strategy provides an opportunity to incorporate anchor principles into estates management, stewardship and disposal. Where feasible, this could be about pledging to open-up assets for community use. In terms of land and property disposal, this is about viewing these assets as more than just a commodity. Despite the pressure to sell-off surplus assets to maximise financial return, this could involve all ICS partners pledging to consider whether any surplus land and property could in the first instance be used to develop of affordable housing, support local businesses or be transferred into community ownership or management.

Introduction

The NHS is not just a service that provides healthcare free at the point of need. It is a social contract with the British people to deliver well-being. Across its wide range of services, the NHS's mission extends beyond making us better when we are ill, it is also about making sure we do not fall ill in the first place – playing a key part in addressing the wider social, economic and environmental determinants of health.

Research published by the Centre for Local Economic Strategies (CLES) in 2019 – in conjunction with The Democracy Collaborative and the Health Foundation – examined the concept of the NHS as a series of anchor institutions and the role they can play in addressing these wider determinants by using spending, employment and estates to contribute to social and economic development.[1] By establishing proof of concept, our work influenced the recent commitment in the NHS Long Term Plan to accelerate good anchor practice across the English NHS.[2]

Interest in the notion of health institutions as anchors has continued to develop within the NHS, with new and innovative practice starting to emerge.[3] And with the introduction of the Integrated Care System (ICS) structure for England in July 2022, we now have another mechanism to encourage the adoption of anchor activity at scale. ICS's have been introduced with the intention to help the NHS support broader social and economic development which is specific to place context.[4] With their focus on collaboration and place, ICS's have the potential to drive improvements in population health and tackle health inequalities by reaching beyond the NHS to work alongside local authorities and other partners.

Yet, recent evidence conducted by the NHS Confederation has highlighted that contributing to economic development is unfamiliar territory for ICS leaders and that support is needed to help them fulfil this objective.[5] As such, in Bedfordshire, Luton and Milton Keynes (BLMK), the new ICS has commissioned CLES to explore its potential as a group of different anchor institutions in contributing to social and economic development.

About this report

Based on CLES's experience of the theory and practice of anchors,[6] we begin in section one with narrative and ambition. BLMK ICS operates across four distinct local authority boundaries and includes several large anchor institutions from health and local government. By harnessing the power of key institutional functions such as spending, employment and estates, we propose that these assets can be deployed to stimulate sustainable economic growth while also alleviating poverty, inequality and lack of opportunity. By providing an analysis of recent progressive economic

[1] CLES and TDC (2019). Health institutions as anchors: establishing proof of concept in the NHS. Link.
[2] NHS (2019). NHS Long Term Plan. Link.
[3] TL Goodwin and D Birch (2021). NHS: supporting those furthest from the labour market. The Health Services Journal. Link.
[4] NHS England (2020). Integrating care: Next steps to building strong and effective integrated care systems across England. Link.
[5] NHS Confederation (2022). The state of integrated care systems 2021/22. Link.
[6] CLES (2020). Growing anchor networks in place: a how to guide. Link.

development practice from elsewhere, we sketch out a guiding narrative that should underpin anchor activity within the ICS going forward.

In sections two, three and four we then consider procurement, employment and estates in turn. In each case we use insights gathered through a series of discussion groups and community of practice meetings with wider stakeholders, to highlight barriers and enablers, as well as examples and case studies of good practice. We then draw upon a number of interviews with personnel across the new ICS structure, to reflect upon this intelligence and arrive at a series of action focused recommendations. The recommendations address how procurement, employment and estates activity could be deployed going forward to develop anchor potential within the ICS. (See appendix one for a full list of stakeholders consulted).

1. Narrative and ambition

"Our aim is simple. We want everyone in our towns, villages and communities to live a longer healthier life. By working together, we can improve the things that are most important to us like giving our children the best start in life, helping our one million population live well for longer and growing our local economy."

BLMK Health and Care Partnership[7]

Context

BLMK ICS covers four distinct geographical places and local authority areas: Bedford Borough, Central Bedfordshire, Luton and Milton Keynes. This total area supports two million jobs and is one of the fastest growing economies in the UK, contributing £110 billon to the UK economy every year.[8]

Nevertheless, across the geography of the ICS, there are places where people live shorter lives, in poorer health. In Luton, for example, women can expect to live a healthy life until they are 60. But just a few miles down the road in Central Bedfordshire, women can expect to live healthily until they are 67. For men the difference is even starker. A man in central Bedfordshire can expect to live healthily for nine years longer than a man in Luton. In Luton and Milton Keynes, the number of people with preventable diseases and cancers is higher than the national average.[9]

While good health is just one fact that helps us live longer healthier lives, many of the things that cause us to become unwell are related to the social determinants of health, such as what job and income we have.[10] In addressing these social determinants, the ICS has a pivotal role to play here in its ability to combine its resources to deliver proactive and preventive services which are shaped by the health and care needs of its local population and have a focus on addressing inequalities.

And to this end, as a collection of significant anchor institutions, the BLMK ICS has a number of place-based assets at its disposal that can be used to affect the economic, social and environmental destiny of its area. Its two acute trusts and four local authority partners, in particular, are substantial drivers of local economic activity. Collectively, they spend hundreds of millions of pounds each year, employ around 17,000 people and hold other significant assets such as land and property.

The power of anchors

Used in the right way, levers such as anchor spending power, employment practices and land use can generate significant impact for local economies, stimulating progressive and sustainable economic development and driving improvements in population health.

[7] BLMK Health and Care Partnership (2022). ICS Animation. Link.
[8] Ibid.
[9] Ibid.
[10] The Health Foundation (2018). What makes us health? An Introduction to the social determinants of health. Link.

In Preston, for example,[11] a group of the city's key anchor institutions adopted a suit of initiatives such as redirecting their public expenditure towards local SMEs, cooperatives, and social enterprises, paying the living wage and building affordable housing. This has increased local economic expenditure, raised average wages and, crucially, it has correlated with improvements in socioeconomic deprivation since the programme has started.[12] Furthermore, a new National Institute for Health and Care Research (NIHR) project has also illuminated further positive evidence. In short, during the period since these interventions have been introduced, there have been fewer mental health problems than would have been expected compared to other similar areas. As a recent paper concludes, these interventions potentially provide an effective model for economic development that leads to substantial health benefits.[13]

Inspired by this approach, many places across the UK have now followed suit. CLES is working with dozens of local authorities, anchor institutions and combined authorities, as well as the UK devolved nations, as part of the wider community wealth building agenda,[14] to tailor anchor-based interventions to the needs of their places.

Developing the vision

In short then, good anchor practice is starting to be enthusiastically adopted in different areas across the UK who are working to make it a key component of their local economic strategies.[15] However, these places are the exception and not the norm, with local economic development departments in local authorities struggling for the capacity and resource to shift practice in a more progressive direction.[16]

But, with the new ICS structure, there may be untapped resource that could be used to assist here.[17] By bringing together the NHS and local government, these structures should in theory enable collaboration around social and economic development, which is of course the fourth core purpose of the new ICSs.[18]

Nevertheless, clear purpose and strategic intent is essential and ICSs cannot afford to be agnostic about the kind of social and economic development activity they are supporting. "Growth of what" can have a significant barring on wider social, economic and environmental outcomes and close attention should be paid to the evidence.

For example, we may have seen strong GDP growth figures over recent decades,[19] and some people have benefitted well,[20] but the proceeds and benefits of this growth have not been felt more widely. At the latest count, the wealthiest 10 per cent of households hold 43 per cent of all the wealth in the

[11] CLES and Preston City Council (2019). How we built community wealth in Preston: achievements and lessons. Link.
[12] Demos and PwC (2018). Good Growth for Cities 2018. Link.
[13] B Barr et al (2022). The mental health and wellbeing impact of a Community Wealth Building programme – a difference-in-differences study. Link.
[14] H Power and TL Goodwin (2021). Community Wealth Building: a history. Link.
[15] TL Goodwin (2022). A new progressive economy is being built locally. CLES. Link.
[16] TL Goodwin et al (2022). A light in the dark: progressive frontiers in local economies. Link
[17] TL Goodwin and D Birch (2021). NHS can use its power as an employer to create a more just society. Health Service Journal. Link.
[18] NHS England (2020). Integrating care: Next steps to building strong and effective integrated care systems across England. Link.
[19] Office for National Statistics (2022). Gross domestic product (Average) per head, CVM market prices. Link.
[20] The Equality Trust (2019). Billionaire Briton. Link.

UK,[21] compared to the bottom 50 per cent that hold only 9 per cent. The richest five households in the UK own more wealth than 13.2 million people.[22]

When it comes to jobs, again growth-led approaches are not necessarily delivering – with low pay and stagnant real wages dominating the headlines. Despite recent stories about shortages and bottlenecks being good for workers,[23] across the majority of the private sector workers are facing falling real pay,[24] compounding the cost-of-living crisis and the impact of rising inflation, with detrimental consequences for health and well-being.[25]

Work is also becoming less effective at warding off poverty. Over the past 15 years, all areas and nations of the UK have seen increases in in-work poverty,[26] while life expectancy has recently stalled for the first time in a century.[27] In BLMK, Luton has the 7th highest level of child poverty in the UK with nearly half of all children there living in poverty.[28]

And furthermore, unless we start to radically shift the composition of our economic growth, we face ecological catastrophe.[29] The latest reports from the UN's International Panel on Climate Change indicates that temperature changes are happening faster, with the likelihood that the world will reach a climate tipping point sooner than originally forecast.[30] In this, the NHS has set itself an ambitious target of reaching net-zero for the emissions that it can directly control by 2040 and 2045 for the emissions it can influence.[31]

But as the evidence from Preston has highlighted, you can grow and develop the economy in such a way so as to produce wider benefits that improve the social determinants of health – rather than hinder them. To this end then, minimising the extraction of wealth and building prosperity for all should be the intention of local economic strategies. Local economies everywhere should now be rejecting the idea that the sole measure of economic success is growth and should be including additional metrics for wellbeing, happiness, the reduction of poverty and carbon emissions.

As such, it is this kind of strategy that BLMK ICS should focus on as it seeks to refine its strategic priorities and develop place-based interventions.

Key actions:

1. Redefine the ICS's ambitions around economic growth and agree a comprehensive measurement framework

In BLMK, the ICS has five strategic priorities (see Figure 1). Economic growth is the fourth priority and this should be finessed to clarify that the ICS is not agnostic about the kind of economic growth that it intends to support. Going forward, the ICS's strategic intentions could be adapted to include a commitment to anchor principles and to the ICS using its power as a series of anchor institutions

[21] Office for National Statistics (2022). Household total wealth in Great Britain: April 2018 to March 2020. Link.
[22] The Equality Trust (2019). Billionaire Britain. Link.
[23] L Elliot (2021). Bottleneck Britain: turmoil has raised job vacancies and firms now jostle for staff. The Guardian. Link.
[24] G Tilley (2022). Jobs and recovery monitor - wage squeeze continues. TUC. Link.
[25] E Yates I Clark and W Rossiter (2021). Local economic governance strategies in the UK's post-industrial cites and the challenges of improving local work and employment conditions. Local Economy, 36(2). Link.
[26] Joseph Rowntree Foundation (2022). UK Poverty 2022: The essential guide to understanding poverty in the UK. Link.
[27] M Marmot (2020). Health Equity in England: The Marmot Review 10 Years On. Link.
[28] End Child Poverty (2022). Child poverty across the UK. Link.
[29] D Meadows et al (1972). The Limits to Growth: A report for The Club of Rome's Project on the predicament of mankind. Universe Books: New York. Link.
[30] IPPC (2021). IPPC Sixth Assessment Report. Link.
[31] NHS England (2022). Delivering a 'Net Zero' National Health Service. Link.

to drive inclusive economic activity and address population health needs in the process. In this, there should be a commitment to using the combined power of its place-based assets – namely public expenditure (procurement), employment and its estates to promote and elevate the grass roots economy.

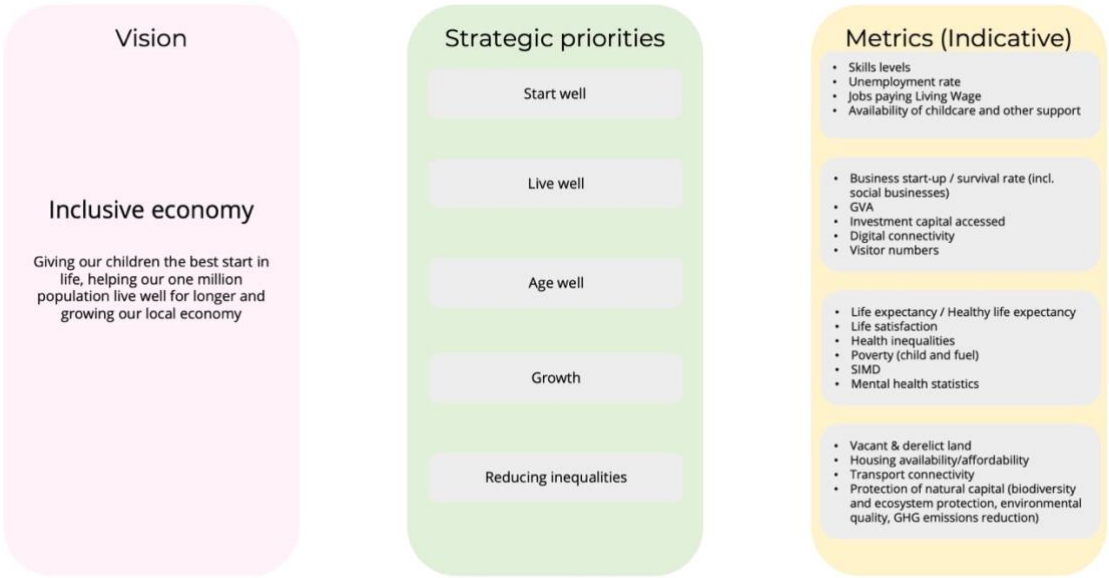
Figure 1. Strategic priorities – BLMK

To this end, the priority here should be on using these assets to support the growth and development of local SMEs, other forms of socially productive business such as social enterprises and employee-owned businesses and promoting employment and skills opportunities across the region, particularly in areas of deprivation. This should be the central narrative which underlies the priority around growth going forward.

Capturing impact through a broad set of metrics is also important and there is a real opportunity for the ICS to look beyond traditional measures such a GDP and GVA and include the kinds of health outcomes that it wants the local economy to generate. A recent report to the Organisation for Economic Co-operation and Development (OECD) proposes that today's primary goals should be environmental sustainability, falling inequality, rising wellbeing (including, but not only, incomes) and strengthening resilience.[32] Adapting and adding to the report's conclusions, we propose the following metrics for consideration, which we have aligned to the ICS's vision and strategic priorities (see Figure 2).

[32] OECD (2020). Beyond Growth: Towards a new economic approach. Link.

Figure 2. Impact measurement



2. Spending

Harnessing the power of public expenditure on goods and services to support local economic development presents a challenge for the NHS. While the NHS in England spends around £6bn a year on consumables, such a gloves and syringes,[33] this is typically rooted through national procurement frameworks and NHS Supply Chain.

Emerging practice

In our recent research with the Health Foundation,[34] we found that the desire within the Department of Health to maximise cost and efficiency savings – by using the NHS as a monopoly purchaser of goods and services – is hindering more progressive spending initiatives. In short, NHS Supply Chain has been targeted as a means of leveraging the NHS's purchasing power on a national scale to aggregate demand, centralise purchasing and deliver better value for money for the NHS and the taxpayer. As such, its predominant focus is on achieving the best price and quality for its customers.

This challenge, in particular, emerged as a common theme throughout the wider stakeholder engagement. A number of stakeholders shared the reflection that "*[NHS] procurement systems across the UK have been designed to produce certain outcomes [namely, generate savings] with no targets around progressive procurement practice*". They are in effect "*almost mandated to use national frameworks to buy most consumables"*. Even in Scotland and Wales, where the national policy frameworks are more supportive, at the practice/delivery level things are "*very much governed by cost and efficiency*".

Nevertheless, despite these challenges we are starting to see pockets of innovation here, with health institutions using their expenditure to support the growth and development of the local economy in a more purposeful way.

Social value frameworks

In the main, this involves greater use of social value frameworks to secure additional value from large contracts when there are opportunities to run local tenders, as opposed to the use of NHS Supply Chain. These frameworks tend to focus on:

- promoting skills and employment, good terms and conditions and developing opportunities for all within the community;
- supporting local supply chains;
- building stronger and deeper relationships with the voluntary, community and social enterprise (VCSE) sector; and
- protecting and improving the environment, ensuring that the places where people live and work are cleaner and greener.

In Essex, for example, the County Council has employed an officer to work across its anchor institutions – including the NHS – to encourage the collective usage of their social value framework. This has been tailored to specific local strategic priorities – namely, increasing sustainable

[33] T Sasse (2020). NHS Procurement. Institute for Government. Link.
[34] CLES and TDC (2019). Health institutions as anchors: establishing proof of concept in the NHS. Link.

employment, increasing skills levels, improving opportunities for young people and reducing Co2 emissions.[35]

Support for local enterprise

In addition, expenditure also provides an opportunity for market shaping and innovation, to encourage more local and socially productive forms of business to flourish – such as triple bottom line SMEs, social enterprises and employee-owned businesses. Consequently, a handful of trusts and health boards are looking to shape the nature of their local markets through their spending activities by specifically supporting the development of local SMEs. Hywel Dda University Health Board in Wales have been working closely with Carmarthenshire County Council, looking at how they can shift some of their expenditure that is not governed by national frameworks towards local businesses, helping them to grow and diversify in the process. Sandwell & West Birmingham NHS Foundation Trust have been working with their local network of anchor institutions to shift expenditure on food and drink towards Black Country suppliers.

Building on this approach, the Northern Care Alliance NHS Foundation Trust have analysed all of their spending data, subtracting anything that is non-influenceable (in other words anything that the trust is expected to purchase through NHS Supply Chain) and have committed to shifting 10% of this expenditure into the local economy.

With a view to hitting this target, the Trust have shared their spending data with their local authority partners. Since 2020, many local authorities now have increased intelligence about local markets in the aftermath of the Coronavirus grant funding process.[36] This money was administered to SMEs by local councils and has resulted in an increased awareness of the capacity local SMEs might have to diversify their activities. In councils such as Fife and Carmarthenshire, for example, they are using this intelligence to target their own procurement expenditure towards growing and diversifying their local SME base. Here, economic development officers are engaging with local SMEs to make them aware of their goods and services pipeline, with a view to more of their supply chains being delivered by these local businesses. Through this engagement these local authorities are using this as an opportunity to address the environmental crisis – supporting local SMEs with retrofit and access to environmental grants. They are also encouraging the adoption of the living wage, as well as initiating discussions around succession planning, to potentially transition to worker ownership. This, in short, enables these local businesses to grow and develop with greater social and environmental purpose.

Insourcing

The Northern Care Alliance have also undertaken a programme of insourcing around their catering offer for both retail and patients, seeing this as an opportunity to address not only issues around quality and cost but also to meet their aspirations as an anchor institution. Insourcing is providing an opportunity to offer improved terms and conditions for staff who have been TUPE'd across onto NHS contracts. It is also helping to bolster their aspirations for more local spending and the Trust have recently contracted a local milk supplier with a view to supporting the local food economy. Furthermore, now that the trust has control over the pricing structure for its retail food offer, it has taken the decision to sell its food at cost price on Sundays to the local population, in order to help address the current cost of living crisis.

Progress to date within the ICS

With a view to exploring how the ICS could use its spending opportunities to support social and economic development, **a procurement practitioners working group has been established**

[35] Essex County Council (2022). Social Value at Essex County Council. Link.
[36] Local Government Association (2021). Supporting councils with business engagement. Link.

across the ICS's geographical area. This includes procurement representatives from the local councils and the acute trusts. However, the feedback from our interviews is that the purpose and parameters of this group are somewhat unclear, as one interviewee explained: "*I think people needed to know why they were there and they weren't clear on why they were there. We haven't had an edict that says 'right you need to do this', so we could talk about what we need to do… If there's no dead line, the networking and the learning sets go out of the window..*"

As it stands, **all four local authorities in the ICS area are committed to leveraging additional social value from their spending activities**. In the acute trusts, our engagement with procurement teams has revealed that while "*it's very much NHS Supply Chain for consumables*", for other area of expenditure such as **linens and laundry, estates contracts, minor works, waste and car parking, these are areas which are starting to come up for retender and could potentially be used to support local economic development**.

However, this presents a new challenge for the NHS, as one interviewee explained: "*[f]rom the 1st April we're supposed to have 10% social value weighting in all our tenders.. but its finding the right questions and then who's going to evaluate on that*"? Nevertheless, the ICS is about to start soft market testing for a new contract for musculoskeletal health services and is committing to work with its local partners to establish appropriate social value criteria.

Key actions:

2. Enable SMEs and other forms of progressive local enterprise to play a greater role in the BLMK economy

In line with the vision set out in action one, and the ICS being purposeful about the kind of economic activity is supports, it should look to develop a commitment across is partners to use spending as a mechanism to grow and develop the grass roots economy. Key to this commitment is integrating procurement data into economic development practice as highlighted above in councils like Fife and Carmarthenshire. **This would involve a number of steps and actions**, as follows.

I. **Members of the procurement practitioners' group could look to analyse their procurement data and identify their influenceable spend**. In other words, money that is currently being spent on goods and services that could in theory be spent with alternative local and more socially productive suppliers – such as triple bottom line SMEs and social enterprises etc. For the NHS, in the first instance, this would exclude anything that is currently being purchased from NHS Supply Chain.

II. **Local authority partners, as well as third sector representatives, could then use their market intelligence to identify potential alternative suppliers**. As described above, this would require local economic development officers to engage with local SMEs and/or social enterprises to make them aware of the potential goods and services pipeline. This engagement would also provide an opportunity to address issues relating to the environmental crisis – supporting local businesses with retrofit and access to environmental grants. It would also be an opportunity to encourage the adoption of the living wage, as well as initiating discussions around succession planning, to potentially transition to worker ownership. In short, enabling these local businesses to grow and develop with greater social and environmental purpose.

    - **This process would ideally involve a collaboration between all local authority partners**. Luton council are already utilising this approach with their own spending data – and it may therefore be preferable to pilot this activity here to establish proof of concept. In addition, our engagement revealed that other councils such as Central Bedfordshire have land that could be used to establish

new business premises, thereby supporting local business growth and development.

III. **The ICS could also explore how this approach could be supported through the commissioning function of its Integrated Care Board (ICB)**. Our insight gathering discussion groups highlighted the fact that the ICB is already starting to consider how it could commission community development workers as a mechanism to support more inclusive economic growth. As one interviewee explained, this could involve a practitioner "*working within a neighbourhood to identify what the needs of the neighbourhood are… Thinking in a more holistic way so not just thinking about their health needs or their social care needs but also thinking about their local employment.*" Adapting and adding to this idea, this resource could also be specifically targeted towards supporting local business growth.

IV. **Ultimately, this approach could be used to support the growth and development of a larger sustainable manufacturing offer in the BLMK area**. As noted above, the NHS in England spends around £6bn on consumables,[37] which includes items like PPE and single use medical instruments such as scalpels and blades. During the pandemic, many supply chains were disrupted and the NHS was forced to turn to local SMEs who were able to quickly adapt their operations to start providing the NHS with the necessary consumables. In southwest Wales, for example, Transcend Packaging – an ethical, forward looking business, committed to environmental sustainability – changed its production to provide a million face shields a week to support the local health boards.[38] With the impact of Brexit on supply chains, the NHS is continuing to face disruption and, as one interviewee explained, "*if you look at the range of stuff that the NHS purchases, I would say that the economic and the supply chain reliability would tell us that things that it made sense originally to manufacture abroad and bring in, there is a case for some of those things to be now manufactured locally*." As such, NHS and local authority partners could build on the approach outlined in actions I-III above and explore the potential and feasibility for an alternative local manufacturing offer. Ultimately, this could be incorporated onto NHS Supply Chain and even be used to provide consumables to other ICSs along the M1 corridor. Theatre instruments are a good case in point here. From an environmental and potentially a cost and supply chain reliability point of view, there is a case to move from single use to reusable. This, as another interviewee pointed out, would mean that you could move to a "*single decontamination and sterile services provider*" which would therefore provide an additional opportunity to use this service requirement to support local economy.

3. Agree a unified approach to securing additional social value during tendering activity

The emergence of BLMK ICS is an opportunity to review applications of social value across the patch, particularly in relation to what the process is for securing additional social value during tendering exercises. Social value weighing has been enthusiastically taken up by many local authorities who are using this opportunity leverage real social, economic and environmental benefit for local people.[39] Building on this approach and progress to date, partners could look to agree weighting targets for their tendering exercises and the procurement practitioners' group could be tasked with establishing a peer leaning process to enable the dissemination of best practice to partners whose processes are less advanced here. Moreover, further collective thought should be given as to the

[37] Institute for Government (2020). NHS Procurement. Link.
[38] TL Goodwin (2020). NHS procurement strategy should aim to boost local economies, not save money. Health Services Journal. Link.
[39] CLES (2017). The Power of Procurement II. Link.

nature of the social value outcomes that are being sought across the patch. In particular, these should be tailored towards payment of the living wage, providing employment opportunities for people in areas of deprivation – including work experience for young people – and, where appropriate, providing opportunities to develop local entrepreneurs (which was another theme that emerged from some of the discussion groups with BLMK stakeholders).

However, it is important that the ambition to secure social value during tenders does not become the panacea for anchor activity across the ICS. Many suppliers have learned how to "play the game" presenting a good impression but ultimately, learning how to manipulate the system.[40] In some cases, this has resulted in larger providers deploying dedicated bid-writing staff to deliberately over-promise the amount of social value they will deliver, in order to gain an advantage in the tendering process.[41] As such, the real size of the prize here for progressive spending should be the activities described in action two, above. Furthermore, rather than retender certain services, when contracts come up for renewal, partners should also consider the merits of insourcing and whether this would be a feasible option.

4. Explore how BLMK could work with other ICSs across England to establish social licensing for NHS supply chain

For many consumables, NHS Supply Chain will always provide the price and reliability that the NHS needs to deliver its services efficiently and effectively. But the NHS also has other challenges. To meet its net zero ambitions, it needs to achieve a net zero supply chain by 2045. If it is to further fulfil its ambitions an anchor institution – to use its assets and behaviour to address the social determinants of health – then ideally NHS Supply Chain should offer guaranteed social returns, such as a living wage employment.

In order to help the NHS achieve these ambitions, BLMK could take the lead here and ultimately look to work with the other 41 ICS leaders to lobby the Department of Health to consider a form of social licensing for NHS Supply Chain. CLES has long been an advocate for social licensing which would mean that suppliers can only enter markets if they have changed their business practices and guaranteed the provision of social benefits to communities and stakeholders. Social licensing would change the rules governing social value, giving companies or sectors the right to trade in public sector markets whilst placing them under reciprocal obligations to offer social returns.[42]

[40] R Butterfield et al (2005). The new public management and managerial roles: The case of the police sergeant. British Journal of Management, 16 (4). Link.
[41] D Harrison and P Edwards (2018). Making Procurement Work for All: Procurement practices as a route to fulfilling work in North East England. Carnegie Trust. Link.
[42] TL Goodwin et al (2020). Restoring public values: the role of public procurement. CLES. Link.

3. Employment, skills and progression

Employment is one of the most important determinants of physical and mental health. People who are long-term unemployed have a lower life expectancy and worse health outcomes than those who are in work.[43] Children growing up in workless households are almost twice as likely to fail at all stages of education compared with children growing up in working families.[44]

Furthermore, the NHS is currently facing an acute employment crisis with staff shortages resulting in the cancellation of around 30,000 operations last year across the NHS.[45]

Emerging practice

As such, in a number of locations, NHS trusts and health boards are taking the lead in deploying progressive employment interventions at local level, which are being used to leverage employment opportunities towards people who are farthest from the jobs market.[46]

For example, a number of NHS trusts and health boards now map their workforce against all postcodes in their locality, with a view to being more inclusive employers. This practice often reveals current employees to be less diverse than the local population as a whole, with a high proportion not resident in the locality they serve. Another commonly observed trend is a relatively low level of employees from areas of high unemployment and deprivation.

Equipped with this information, trusts and health boards are able to take purposeful action: to lever employment opportunities towards individuals who are currently furthest from the jobs market.

Hywel Dda

During the pandemic, Hywel Dda University Health Board in southwest Wales needed to recruit 2,000 posts – from cleaners and porters to healthcare support workers. This presented an opportunity to recruit specifically from the local population and to target sectors such as hospitality, which has been disproportionately affected by the pandemic. To help this transition, they have changed typical person specification criteria – such as "experience of being a carer" or "working in the NHS" – to focus instead on values and behaviours. This has in turn led to a wider programme of work around reviewing person specifications for jobs, to make them less intimidating for local applicants.

ICAN

In the West Midlands, the Birmingham & Solihull Integrated Care System, in partnership with the Birmingham Anchor Institution Network, is leading a programme known as ICAN across all of its employing providers. The three-year programme will deliver job opportunities for unemployed and young people, targeting economically disadvantaged areas across Birmingham and Solihull. It

[43] M Bartley et al. (2005). Chapter 5: Health and labour market disadvantage: unemployment, non-employment and job insecurity. Social Determinants of Health 2nd Edition. Oxford University Press: Oxford.
[44] Department for Work and Pensions (2017). Improving Lives, Helping Workless Families. Link.
[45] Sky News (2022). NHS staff shortages led to 30,000 cancelled operations last year, data reveals. Link.
[46] TL Goodwin and D Birch (2021). NHS: supporting those furthest from the labour market. The Health Services Journal Link.

includes the provision of tailor made "get into work" development and support programmes, with careers, interview, application support and a programme of post-employment mentorship. The programme launched in November 2021 and has to date delivered 239 job outcomes with a further 322 applicants either currently in, or awaiting, training.

Northern Care Alliance

In Greater Manchester, the Northern Care Alliance NHS Foundation Trust has bypassed the advert and interview process for many of their entry level positions and they are now reserving these positions for the recipients of targeted pre-employment training programmes.

Having mapped their employment profile, they have identified deprived postcodes where they are not employing people and have designed specific pre-employment training packages to help these local residents to enter their workplace. These programmes have been developed in conjunction with the local community and they are calibrated to help groups, such as BAME people, get ready for work. Within the next three years, their aim is to be providing a 1000 pre-employment places linked to jobs every year.

Through the adoption of these programmes, these health institutions are starting to change the narrative around their workforce by using their power as employers to tackle the social determinants of health and create a more just society. It's not about just wanting "*the best person for the job*", but using the job to do the best by the people who make up your local economy. In short, "*good jobs equal good well-being, equals good health and a lower likelihood of them being seen as a patient*."

Progress to date within the ICS

Engagement with the employment team within the ICS has revealed that work is currently underway within the progressive employment practice space. **This has predominantly involved the establishment of a health and care academy at the Bedfordshire Hospitals NHS Foundation Trust** which targets work experience and careers advice towards young people aged 15-20. The academy provides an introduction to the wide variety of potential careers within health and care across the ICS footprint. While this is largely about explaining the range of health and care careers on offer, as one interviewee explained, this is also about:

> "*changing some of their perceptions or their aspirations as to what they want to be or how they could get into it, because they talk to them about the different routes in, so you could go to university and be a nurse… Or you could go into many careers via an apprenticeship route - so if university is not for you or your financial situation means that it's not for you*."

Launched just before the onset of Covid-19, the academy had to adapt to online delivery, rather than face to face. However, this has meant that the programme has been able to accommodate a larger number of people than was originally planned.

While the academy currently targets its resources towards Central Bedfordshire and Luton, **it has recently received funding to extend the reach of this programme into the Milton Keynes area during 2023-2024**. With the extra money, this will enable the academy to work with more schools in more areas and to consider how they could take that offer to some of the harder to reach communities across the ICS footprint.

In terms of linking pre-employment support to jobs within the NHS, this activity is very much at the inception and is currently rather "*piecemeal*". The local provider trusts have done some work with organisations like Indeed – to do pre-employment preparation – and there have been early conversations with the Prince's Trust about linking the NHS cadette scheme into paid employment.

However, the workforce team lacks a complete picture of the support on offer across the footprint and work is needed to develop this intelligence.

Key actions:

5. Target skills development and employment opportunities towards people and communities who need them the most

To help alleviate poverty, deprivation and health inequalities within BLMK, it is within the gift of all anchors to consider how their employment and skills development opportunities support could be targeted towards those who are most in need.

The BLMK People Board could the take the lead here and could look to scale and amplify the activity to date across the geographical footprint. It could begin by seeking to build a greater understanding of the local provision of employment support for those furthest from the labour market and then look to develop a pilot programme similar to ICAN that would remove as many barriers to employment as possible. Ultimately, the ICS could then look to extend the programme beyond its NHS partners. This work would involve the following steps.

I. **Develop a socio-economic profile of health and care academy candidates.** The health and care academy is a good way of raising awareness and aspirations in relation to careers in the wider health sector. With a view to progressing its work, activity should focus on developing a better socio-economic profile of existing candidates to determine where the gaps are and to thereby guide the continuation and expansion of the academy during 2023-2024.
II. **Map the employment profile of the provider trusts**. In addition to the provision of work experience, it is important to make best use of more substantial employment opportunities. In line with emerging practice from elsewhere, the ICS could work with its large provider trusts to map their respective employment profiles and identify any deprived postcodes where they are not employing people.
III. **Map the totality of employment support interventions across its geographical footprint**. The ICS could work with its partners to audit the nature of employment support on offer within BLMK and again look to identify any significant gaps. With respect to actions I-III, the workforce team within the ICS felt that that they could potentially work in partnership with public health on this agenda as there is a regular stream of public health registrars rotating through the system who are required to complete a six-month project. This was flagged as a potential resource that could be harnessed to help complete the mapping exercises.
IV. **Design an overarching skills and employment programme**. With the health and care academy, as well as the myriad of job opportunities on offer, the ICS has significant assets that could be used to develop an overarching programme to support routes to employment for those farthest from the labour market. The mapping exercises outlined above should provide the necessary intelligence. Depending on what is unearthed by this process, the ICS may need to develop additional employment support. At this stage it would be prudent to reach out to the other health systems mentioned above who have already designed similar schemes.

4. Estates

How land and property assets are owned and managed are key features of any local economy. While traditional economic development and planning approaches might only measure the value of these assets in economic terms, developing an inclusive economy across BLMK would see these assets harnessed to serve wider goals.

Emerging practice

As with spending, the progressive usage of land and property is particularly challenging within an NHS context. NHS estates strategies have been heavily scrutinised in recent years. In 2017, Sir Robert Naylor's review of NHS property and estates, set out recommendations as to how the government could fund NHS reforms by selling land it no longer needs and buildings that are expensive to maintain.[47] This has led to local health systems being encouraged to sell off land to qualify for transformation funding.[48] But as stakeholders reflected, this has led to short-termism:

> *"getting rid of estates, flogging it off, whatever they can get the money for, in order to show their annual accounts are in balance, in order to qualify for this further cash… [B]ut meanwhile, they've sold this asset, which might be useful to them in the future."*

Despite this shift, however, some areas are bucking the trend and innovative practice has continued to emerge.

Affordable housing

East Lancashire Hospitals NHS Trust are currently involved in two projects to develop affordable housing, working in partnership with a local housing association as well as Burnley Council to provide affordable housing and accommodation for key workers. Currently in development, is a scheme opposite the Royal Blackburn Teaching Hospital that will include 150 flats for affordable rent by medical staff there and at Burnley General Hospital.[49]

At Sandwell and West Birmingham Hospitals NHS Foundation Trust, they have previously secured a grant to convert one of their empty buildings into accommodation for homeless people aged 16-24. Furthermore, they have recently partnered with the charity St Basils to provide new, affordable rented apartments for young people. The scheme involves a capital contribution from Sandwell Council to fund the refurbishment of three blocks that are owned by the NHS Trust. The refurbishment will provide 54 self-contained one-bedroom affordable rented apartments. The ground-breaking scheme will enable young people who would otherwise be at risk of homelessness to have truly affordable accommodation, enabling them to secure and sustain employment, thereby preventing and relieving homelessness affecting young people in Sandwell.[50]

[47] R Naylor (2017). NHS property and estates: Naylor review. Department of Health and Social Care. Link.
[48] J Omerod (2018). The great NHS property sell-off gathers pace. Open Democracy. Link.
[49] B Jacobs (2021). New Blackburn homes for East Lancashire's NHS hospital hero's. Lancashire Telegraph. Link.
[50] Sandwell Metropolitan Borough Council (2022). Agreement with St Basils to provide affordable rented homes for young people. Link.

Opening-up land and assets for community use

University Hospitals Birmingham NHS Foundation Trust regularly allow local community groups and charities to make use of their buildings and facilities for free, giving over their conference centre to let local charities run annual conferences, for example. The Trust run a local farmers market on their land which is specifically targeted at micro enterprise within a 30-mile radius. They are also looking at how their lecture theatres could be used to screen films for free for the local community.

Similarly, other Trusts such as East Lancashire are very willing to let local community groups make use of their buildings and facilities to hold meetings out of hours. They have also used the land at the front of their hospital sites to hold events focused on environmental sustainability and healthy eating.

Health and wellbeing hubs

The development of mixed-use sites for health and care is becoming more common within health systems across the UK. To some extent, the development of these assets is merely part of the continuing evolution of health and care services, but with the opportunity to create and promote wider social and economic benefit, they can be important contributors to the anchors' agenda and the development of more inclusive local economies.

Liverpool University Hospitals NHS Foundation Trust are currently looking to develop the north site of Aintree Hospital, which is currently underused and vacant in some areas. Rather than simply selling off this land to the highest bidder the Trust have developed a plan with local partners to transform the site into a Health and Wellbeing Campus for Liverpool City Region. The campus would complement the acute services delivered on the hospital site and help meet wider social needs. Current plans envision a high-quality mixed-use development including:

- up to 400 mixed residential units, a part of which would be dedicated key worker accommodation;
- intermediate residential care;
- a GP surgery;
- education and community spaces;
- open space;
- cafés, restaurants and retail; and,
- other specialist accommodation, including stepdown care units, rehab accommodation, and a patient/visitor hotel.

In southwest Wales, Carmarthenshire Council are working in partnership with Hywel Dda University Health Board, making use of levelling-up funding to acquire a former Debenhams' department store and convert the building into a community health hub with gym facilities. Rather than seeing this land sold off to a private developer, this conversion will not only provide vital health services but it will help create footfall on the high street to support local businesses.

Progress to date within the ICS

BLMK ICS has a number of sites that are coming up for disposal in the next two years. Currently, the disposal strategy involves consultation with local partners via the capital and estates oversight group and at the wider one public estate forum to consider how such opportunities could be maximised. In terms of linking their strategic aims to the anchors' agenda, interviewees from the estates team reflected that they are "*currently tinkering around the edges of this.*" However, they are in the process of renewing their estates strategy and are keen to include some broader

commitments around using land and property to support their contributions as an anchor institution:

> *"[W]e could absolutely aim to include in there some principles around our approach to disposals and a commitment about what we expect our partners to sign up to in terms of disposals… We'd really value guidance and best practice around what's happening elsewhere."*

Key actions:

6. Deepen the function of land usage and disposal across the ICS footprint

The upcoming refresh of the ICS estates strategy provides an opportunity to incorporate anchor principles into estates management, stewardship and disposal.

As outlined above, where feasible, this could be about pledging to open-up assets for community use.

In terms of land and property disposal, this is about viewing these assets as more than just a commodity. Despite the pressure to sell-off surplus assets to maximise financial return, this could involve all ICS partners pledging to consider whether any surplus land and property could in the first instance be used to generate the kind of wider returns outlined above, particularly in relation to the development of affordable housing. Moreover, surplus land and property could also potentially be used to facilitate action two – supporting more SMEs and other forms of progressive local enterprise to play a greater role in the BLMK economy. Opportunities for local businesses to supply local anchors with more of their goods and services may require these businesses to grow and diversify which, in turn, may generate the need to find new business premises. As such, where feasible, surplus land and property could also be sold or rented out to support this end.

Finally, it may be the case that surplus land property could be transferred into community ownership or management. Closer working with the VCSE sector to understand demand for this activity would therefore be useful.

Conclusion and next steps

The NHS's role a series of different anchor institutions has never been more important. As local economies attempt to navigate the multiple crisis that are being faced by people and communities across the country, the new ICSs could play a pivotal role in the pursuit of more inclusive local economies.

As this action plan demonstrates, the evidence is starting to suggest that anchor-based approaches can provide an effective model for economic development that leads to substantial health benefits. What is more, the NHS and its partners have a number of key assets at their disposal that can be deployed in a more purposeful way to support this different kind of economic activity.

To this end then, the action plan does offer something of a blueprint as to how BLMK ICS can start to fulfil its objectives around social and economic development – a blueprint that is about rebooting the system rather than tinkering around the edges.

We strongly recommend that BLMK ICS moves to operationalise this action plan as soon as possible. There is not necessarily a complete logical order as to how the ICS should approach this task and there may be quick wins and low hanging fruit that could be immediately addressed in some areas.

In conclusion, we would however recommend that finessing the vision is fundamental and should be addressed as a matter of priority. The ICS has made a great start here but as we have made clear above, it cannot be agnostic about the kind of economic growth it will support going forward. Growth for growth's sake does not trickle down and has fuelled the very social, economic and environmental challenges we must now address.

Start small if needs be but embrace the substantive changes to practice that will be required to deliver a truly inclusive economy across the BLMK area.

Appendix – List of stakeholders

BLMK

Felicity Cox	Chief Executive Officer, Bedfordshire, Luton and Milton Keynes Integrated Care Board
Rima Makarem	Chair, Bedfordshire, Luton and Milton Keynes Integrated Care Board
Tracey Stock	Chair, Bedfordshire, Luton and Milton Keynes Integrated Care Partnership
Anne Brierley	Chief Transformation Officer, Bedfordshire, Luton and Milton Keynes Integrated Care Board
Tim Simmance	Associate Director of Sustainability and Growth, Bedfordshire, Luton and Milton Keynes Integrated Care Board
Nikki Barnes	Head of System & ICB Estates, Bedfordshire, Luton and Milton Keynes Integrated Care Board
Catherine Jackson	Senior Workforce Transformation Project Manager, Bedfordshire, Luton and Milton Keynes Integrated Care Board
Kathryn Moody	Director of Contracting, Bedfordshire, Luton and Milton Keynes Integrated Care Board
Jacqui Nicholls	Head of Procurement, Bedfordshire Hospitals NHS Foundation Trust
Mark Thomas	Chief Digital and Information Officer, Bedfordshire, Luton and Milton Keynes Integrated Care Board
Marcel Coiffait	Chief Executive Officer, Central Bedfordshire Council
Fergus McLardy	Programme Manager, Community Wealth Building, Luton Council

Other NHS Stakeholders

Sara Bordoley	Policy Delivery Lead (anchors), NHS England
Dave Buck	Senior Fellow, The King's Fund
Michael Wood	Head of Health Economic Partnerships, The NHS Confederation
Lorna Renwick	Organisational Lead – NHS Leadership, Health Equity, Public Health Scotland
Neil Hind	Net Zero and Social Value Consultant, Greater Manchester Integrated Care
Dave Sweeney	Executive Director of Partnerships, Cheshire and Merseyside Health and Care Partnership
Martin Higgins	Strategic Programme Manager, Public Health and Health Policy, NHS Lothian
Huw Thomas	Director of Finance, Hywel Dda University Health Board
Gemma Deverill	Assistant Head of Procurement, Hywel Dda University Health Board
Vivian Smith	Essex Anchor Social Value Officer, Essex County Council
Tracey Leforte	Group Director of Procurement, Mid and South Essex NHS Foundation Trust
Conrad Parke	Birmingham Anchor Network Co-ordinator, CLES
Ajminara Begum	Employment and Mentoring Co-ordinator, ICAN
Donna McLaughlin	Director of Social Value, Northern Care Alliance NHS Foundation Trust
Heidi Barnard	Group Head of Sustainability, Northern Care Alliance NHS Foundation Trust
Mark Storey	Head of Procurement, Northern Care Alliance NHS Foundation Trust

James Maguire	Director of Estates and Facilities, East Lancashire Hospitals NHS Trust
Lawrence Kelly	Learning Works Manager, Sandwell & West Birmingham Hospitals NHS Trust
Nav Kiran Sharma	Widening Participation Project Support Officer, Sandwell & West Birmingham Hospitals NHS Trust
Mike Hanson	Director of Procurement, Sandwell & West Birmingham Hospitals NHS Trust
Paul Mellor	Director of Procurement, Sandwell & West Birmingham Hospitals NHS Trust
Rob Fallon	Property Management and Sustainability Manager, Liverpool University Hospitals NHS Foundation Trust

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DRAFT Winter 2023/24 Planning Submission

ICB name:	**Bedfordshire, Luton, and Milton Keynes System**
Approved for submission by:	Anne Brierley – Chief Transformation Officer BLMK ICB

Notes on completion:

1. This document outlines the narrative key lines of enquiry that ICBs are asked to respond to as part of the NHS England winter planning exercise for 2023/24.
2. The purpose of this document, and the associated H2 numerical planning template, is to support ICBs to lead a system-wide planning processes ahead of winter.
3. The narrative questions in this document are designed to provide a prompt for areas that required consideration, and to provide the necessary assurance that steps have been taken at a system-level to prepare for a resilient winter period.
4. The narrative submission should be completed in conjunction with the H2 numerical planning submission, and system partners should refer to the system winter roles and responsibilities issued as part of the winter planning process on 27 July 2023.
5. Recently completed UEC Maturity Indices that were issued as part of the NHS Impact improvement offer should be considered alongside these plans to inform system thinking on which areas locally require the most focussed attention in the run up to, and during, winter.
6. ICBs are responsible for producing one comprehensive response for the system, there should be a focus on ensuring that all parts of the system, including Local Authority partners, are engaged in developing this. Updated intermediate care capacity and demand plans at HWB level will need to be agreed with local authorities and submitted in October as part of BCF quarterly reporting. The BCF plans should reflect agreed changes to capacity and demand management agreed in these ICB plans.
7. There is a total of six key lines of enquiry with associated questions across the following areas:

    a. System-working
    b. High-impact interventions
    c. Discharge, intermediate care, and social care
    d. H2 numerical planning submission
    e. Surge plans
    f. Workforce

KLOE 1: How will the system work together to deliver on its collective responsibilities?

Key question and points to consider	Milton Keynes (MK Together)	Bedfordshire and Luton (Bedfordshire Care Alliance)
KLOE-1.1: How has each part of the system been engaged? • How have roles and responsibilities been communicated to and agreed with each part of the system? • How has each part of the system been engaged to support the development and delivery of the winter plan? How have local authority, social care and VCSE (voluntary, community or social enterprise) partners been engaged with developing the system winter plan?	The MK System works together through a partnership governance structure set up to improve system flow (ISF) under the MK Deal. This consists of the MK Joint Leadership Team (JLT), the MK ISF Steering Group, MK Operational Status Group (OSG) and the MK ISF Core Project Group. A winter plan is being developed at place. The PRN00645 Letter and Appendix B - System roles and responsibilities, has been shared and discussed along with the iUEC pathway maturity self-assessment which was completed by the MK OSG. The Voluntary Care sector presented initiatives which offer further discharge support and admission avoidance through Winter. MK City Council (MKCC) are key partners and Social Services chair the MK ISF Core Project Group. Age UK MK is providing additional direct support to BCF schemes while Healthwatch is collating qualitative information on patient experience as part of a survey to inform the winter plan.	The Bedfordshire Care Alliance is collaboratively working together across health, social care and voluntary care to embed identified opportunities and improvements to achieve a sustainable workforce through winter. There is a clear winter plan at place level, with identified roles and responsibilities across the system, which has been discussed and continues to be refreshed at the Bedfordshire Delivery Group. This allows identification of any gaps and challenges to performance for which support, and mutual aid is enhanced. The Voluntary Care sector presented initiatives which offer further discharge support and admission avoidance through Winter. Key themes and challenges and risks to performance and delivery of the winter plan are raised and discussed through system and regional assurance meetings.
KLOE-1.2: How will you assure that each part of the system is delivering against	MK System partners are held to account for delivering their roles and responsibilities by MK JLT and by the MK ISFSG.	All Health and Social care partners across Bedfordshire and Luton hold daily quick fire calls at 09.30 each morning (5

its roles and responsibilities? • What is the mechanism for system partners to hold one another to account for delivering on their roles and responsibilities? • How have key interdependencies between parts of the system been identified, and how will they be managed? • What are the key risks to delivery of the plan in each part of the system, and how will they be mitigated?	A MK Together winter plan is being developed. Key interdependencies are identified through the work of MK JLT, MK ISFSG, MK ISF Core Project Group and Section 256 initiatives. In terms of operations, interdependencies are managed by the MK OSG weekly system call (stepped up and held more frequently in times of escalation), review of the capacity and demand SitRep and SHREWD indicators and via the daily Ready to Transfer List (RTTL) conference calls and regular Multi-Agency Discharge Events (MADE) e.g., planned ahead of industrial action and bank holidays. Key risks include demand exceeding planned activity / trajectories, workforce issues (staff shortages, sickness absence, further industrial action), use of escalation beds, lack of community capacity / ability to meet the care needs of more complex patients in traditional care home settings. Mitigating actions include: introducing incentives for home care agencies to support increased levels of discharge, ensuring vaccinations are up to date, increased reablement capacity, forthcoming Care and Therapy Academy will increase the skill set of the Reablement Team and HCAs to provide a more therapy-led intervention and reduce deconditioning, the Virtual Ward hub for frailty is up and running (respiratory and cardio to open next), UCR Access to the Ambulance Stack is now operational, to support with admission avoidance as a result of a fall.	days a week). During the quick fire call operational challenges are discussed, with a view to resolve and or support, to optimize daily flow. SHREWD supports this call to inform predicted system pressures and develop a strategy ahead of time. We have a dedicated system escalation WhatsApp which is utilized daily to inform partners of deterioration of standards to patient risks and request increased level of support and capacity across Health and Social Care. We have an open-door approach, whereby all system partners are able to attend any acute internal meetings that support daily flow. The Bedfordshire Delivery Group has a standing agenda item on any escalation priorities which require discussion and mitigation. This group includes operational and strategic leads across the system to ensure that capacity can be moved and released in other areas to support flow and patient safety. The Bedfordshire Delivery Group informs the system and regional assurance groups of their activity and plans, which allows identification of improvements, challenges, risks and opportunities. This forum is also used to request support for

		any risk mitigation. Key risks include. workforce and wellbeing, Mental demand on all ages, Bedford SDEC non funded and therefore non-functional, the use of escalation beds, demand out stripping capacity, the continuous industrial action and ability to meet the care needs of more complex patients in traditional care home settings. We have in place local authority a targeted rate increase across nursing, residential care, support living and home care from October 23, to support providers sustainability over the Winter Period. The discharge fund is being used to increase capacity of reablement services and the Councils care homes by incentivising workers with increased pay to mitigate high demand pressures through Winter. Each internal care home as a winter pressure plan which includes banks works to meet pressures. Cohorts of nursing associates and registered nurses have all been offered jobs within the acute sector, supported by continuous overseas recruitment. Dedicated senior nurses have been recruited on each site to manage escalation beds through Winter to maintain quality and patient safety. Mental health have established a UEC Board to co-produce and drive improvements that support services users to seek other alternative pathways to ED. We have a embedded Access to the Stack pathway and a new unscheduled care hub, with a dedicated paramedic and ED consultant, to support non conveyance to hospital

KLOE-1.3: How will the system deliver on the roles and responsibilities identified by NHSE - respond for each area as below:		

Integrated Care Boards	To ensure that the system delivers on the roles and responsibilities identified by NHSE which reflects the needs of all age groups, which includes the CYP and MH services. BLMK ICB has carried out the below actions.
	
	• The development of a comprehensive winter plan, to include demand and capacity modelling from across the entire Health and social care system to facilitate the timely discharge of patients across acute and community hospitals and services.
	• Identified 4 high impact actions from the maturity self-assessment supported by IUEC Champions for delivery. We have further identified other critical issues in BLMK which are not necessarily highlighted in these metrics. These include:
	  ○ Use of escalation / surge beds in acute (elective) clinical settings including plans to de-escalate additional capacity.
	  ○ Spot purchase of intermediate care beds and any under-utilisation of commissioned beds
	  ○ Delays transferring patients who are non-CTR into onward pathways.
	  ○ Workforce challenges affecting home care provision in some Boroughs.
	  ○ Urgent (same day) capacity pressures (whilst HII assessment includes SDEC, need to understand same day pressures across the system
	  ○ Step-down accommodation and crisis (overnight) capacity for mental health (all ages)
	• Through our robust governance structures, we have fostered a culture of partnership working to ensure a coordinated and resilient system during winter. We manage our risks pro-actively to ensure they are balances across health and social care. We have a system in place to hold partners to account for the deliverables in the winter plan.
	• We are planning to deliver late September a systemwide winter planning exercise to test our escalation plan and additional capacity measurements that have been introduced, this will be underpinned by our established SCC, and reframing our action cards in line with the new OPEL framework in a constant manner with the support of our cloud platform SHREWD.	

	• IPC are actively involved and contribute across winter planning also provides support to care homes and any IPC challenges that may incur a bottleneck in patient flow and enable clinical risk sharing across the system. • The Voluntary Care sector has presented initiatives which offer further discharge support and admission avoidance through Winter and attends our internal/external meetings. • We have initiated early planning measure to ensure a sufficient workforce supply, KLOE details. • We have a care transfer hub in the Luton site, and we have a plan for implementation in the Bedford site and Milton Keynes university Hospital to reduce variation and maximise SPOA access to services by Winter 2023, to include the expansion of the DoS. • Dedicated clinical community bed managers in place to ensure capacity and resources are escalated and actions progressed with robust recovery plan in place whilst capturing the impact of interventions and people's functional outcome and long-term care needs. • VWs in place and achieving against the planned trajectory with appropriate step up and step-down capacity aligned to winter flow priorities. • Fully embedded UCR response, available 7 days a week, and is available 8-8. Bedfordshire have an unscheduled care hub to works alongside the UCR team to pull from the stack. Milton Keynes have implemented a pull from the ambulance stack for patients with falls. • EOL and Palliative care remain a high priority area according to mandated requirements. An adult and Childrens Palliative and EOL strategic model is in place with a clear plan across partners to streamline and embed equitable pathways which includes the review of EPaCCS and the development of this to include children. A BI dashboard is in place to inform of trends, prioritise areas of weakness and identify and learn from areas of strength. This is inclusive of all hospice information. Success criteria is agreed.

Objective	Success Criteria
1. Personalised Care Planning	Everyone approaching the end of life should have a personalised care and support plan to reflect their changing needs and wishes
2. Electronic Shared Care Records	The plan should be shared with all those who may be involved in delivering care, so that it informs clinical and professional decision making and encompass the recording and sharing of preferences at the end of life. There should be ambitious local targets for the rollout of systems for sharing digital records
3. Evidence and Information	To ensure a better response to dying, death and bereavement, the commissioners and local organisations that give care need accurate and up to date information that can help improve services
4. Involving, supporting and caring for those important to the dying person	This must encompass good bereavement and pre-bereavement care, including for children and young people. It must also respond to the needs of those who are affected by death caused by sudden illness or trauma, including suicide
5. Education and Training	It is vital that every locality and every profession has a framework for their education, training and continuing professional development, to achieve and maintain this competence
6. 24/7 Access	Every person at the end of life should have access to 24/7 services as needed as a matter of course
7.Co-design / lived experience	Systems of end of life care are best designed in collaboration with people who have personal and professional experience of palliative and end of life care

- We have established CHC and fast track teams and pathways both out of acute and community services and these pathways are included as part of our efficiency improvement programme.
- See Primary Care section for PC recovery plan.
- 111 Homeworking for eligible staff members, both clinical and non clinical has also been implemented as BAU to support the resilience of our services and work life balance.
- 111 Bank contact centre and operational staff will be utilised where possible to support short notice sickness absence and increase in demand.
- 111Workforce modelling ensures confidence in workforce capacity and the OOH clinical workforce is skill mixed to ensure flexibility.
- Category 3 & 4 plus Emergency Dept disposition validation remains a high priority for 111, our workforce plans are matched against predicted activity and surge plans are in place, agreed with commissioners/ICB to mitigate the risk of increased activity. Recent innovations include a 111 – EEAST/SCAS liaison manager to review learning, pathways and escalations.

Acute and Specialist NHS Trusts	SDEC is a functional and bespoke unit with a wide range of assessment services available (to include VTE and OPAT), along with a 26 bedded acute medical assessment ward. SDEC is open 14hrs on weekdays (12hrs for surgical SDEC) with 10hrs at a weekend for both services with streaming of patients directly from ED. We continue to work towards an extended weekend service of 12hrs. Developing clear frailty pathways and protocols with equal access to reduce variation in provision and ensuring specific services meet demand and support early intervention, prevention and avoid admission by implementing standardised assessment tolls and strengthening community-based resource and services such home care, rehabilitation and social support programmes. Improvement work stream in place to address variation in Board round practice across all inpatient areas. MKUH hold weekly LLOS meetings with system partners to progress patients out of hospital and agree next steps. There is an improvement workstream committed to reducing LLOS which is inclusive of our commissioned community Seacole beds. A proposal for a new MK Integrated Discharge Hub (IDH) has been developed, to be physically located at MKUH to assist patients to	The Luton site have a fully functional SDEC that is open 24/7 with a appropriate clinical teams based on the unit. 31% of daily SDEC attendances of non-elective activity is recorded as 0-day length of stay, national standard is 33% The Bedford site have limited SDEC capacity which is bedded at times of peak ED pressure to enable ambulance handovers. Developing clear frailty pathways and protocols with equal access to reduce variation in provision and ensuring specific services meet demand and support early intervention, prevention and avoid admission by implementing standardised assessment tolls and strengthening community-based resource and services such home care, rehabilitation and social support programmes. GaitSmart is an innovative technology that provides an objective measure of gait/walking ability in a patient friendly report. It is quick and easy for trained staff to use in a range of settings and provides an opportunity to improve muscle strength and balance and reduce the risk of falls. Sensors are attached to the patient and a short walking test is undertaken. A report is produced showing several objective measures of gait, which are combined into an overall gait score. A personalised plan of six exercises most relevant to the gait deficits are recommended from the analysis. The exercises are tailored to the patient's needs and the patient returns at set intervals to measure progress and modify the

	navigate services both admission avoidance and discharge. There will be enhanced hours and an expanded team. The aim is for the Hub to be operational by late Winter 23-24. MKUH are experiencing data quality issues and non-submission of discharge and NcTR data. NHSE colleagues are supporting BI teams to resolve. The ambition is to report accurate data for September 2023 There are daily conference calls in place to discuss each patient, agree their pathway and discharge requirements. SCAS CQC rating was inadequate (safety and leadership. A robust oversight and assurance plan is in place., which is broken down into 4 key priority areas. Locally MK are under target but have a clear trajectory for improvement .80% of ambulance handovers were within 30 mins, with an average handover time of 23mins (July 2023) There was a data gap with EoE NHSE, this has now been resolved and data flows have been initiated. Milton Keynes has an up-to-date internal professional standard in place. Review of Pathway 1 has been undertaken to streamline services and remove duplication. Four options have been developed including for a community hub with one pathway and service. The Task Group reviewing Pathway 2 has identified three options including wrapping care around the patient and moving to a single site that would involve repurposing a building to accommodate the colocation of a	exercise plan as needed. We are piloting use of GaitSmart for D2A patients in New Meppershall and, if successful, hope to expand the project to include other D2A beds across BLMK. The BCA is developing an integrated discharge team and board round standards have been set and agreed, these will be in place by November. This will tackle variation across wards to embed best practice. Patient pathway will be identified at board round and discharge ready date set. Identification of palliative/fast track/ EOL patients will trigger complex planning involving relevant services. As the Bedford site this is mitigated, there is a daily triage call, with system partners to discuss each patient, agree their pathway and discharge requirements. On the Luton site there 2/3 weekly (depending on demand) PTL to discuss and plan for patients System partners have committed to a reduction LOS by 3 days (Bedford site) by winter 2023. These required improvements are supported by the BCA improvement plan. Across both sites there are weekly LLOS meetings held with system to progress patients out of hospital, which are attended by the Medical/ Deputy Director.

	number of existing services: WICU, Dementia and Step-Down Beds. A dedicated improvement is required to ensure that our Seacole commissioned beds are easily accessible in a timely manner and are utilised effectively. This will need to be supported by therapy provision and LA engagement to reduce delays and bed blocking. The new national 4-hour standard is 76% and MKUH is below planned performance. There has been a drop in performance from 2022/23 due to internal changes. This has been recognised and an improvement plan is being revised to meet improved trajectories. MKUH is 4th in the region for 4-hour performance. The new 12 journey time that has recently been implemented shows MKUH are one of the top performing trusts across the region. The BLMK system partners have modelled the workforce requirement for staff to be able to deliver as part of the integrated workforce planning undertaken with local and regional colleagues. As a system we are ahead of the trajectory for the 50K nurse recruitment ensuring the required level of staffing can be supported. This is supported through our Head of Safer Staffing who works with our Partner organisations to ensure actions can be taken to support demand and delivery. Between June 2022 and May 2023, there were 751 Nursing starters across BLMK. The system has undertaken a collaborative recruitment campaign to fill the vacancies within the HCSW workforce,	The Luton site have a high daily discharge rate with a integrated discharge team. There are challenges around P2, intermediate care beds which impacts NcTR numbers. A review of existing contracts is being undertaken to support the care homes to accept patients in a timely manner to reduce spot purchases. There is a BCA improvement work plan across all pathways which includes embedding an integrated discharge team at the Bedford site and to enable the Acute discharge officers to plan and manage all discharges. This will allow community providers to have 'pull' approach to facilitate flow. Across both 'discharge ready' date is being embedded and work is being undertaken to ensure accurate reporting as per National requirements There is a very strong correlation between *Cat 2 performance and hours lost due to handover; therefore, region have set BHT a target of 54 lost hours per week. EEAST are implementing the staggering of breaks to reduce ambulances batching Recovery plan in place to support reduction in hours lost including a specific focus on PIN compliance and 100% of handovers within 30 minutes. The Bedford site is one of the highest achieving in all metrics across the region.

	including considerations for workforce required to deliver services throughout Winter. System partners have engaged in the collaborative campaign including Acute Trusts, Social Care and Primary Care. Early evaluations are showing significant increase in applications and shortlisting within our acute providers. Further attraction campaign for non-registered staff in the community with council and AHP partners planned for end of September which will support winter supply. To support retention of the workforce across Winter the ICS have implemented Legacy roles and have eight legacy roles in the system, exceeding numbers across the EoE region. MKUH are exemplar with NHS Flex and have developed a Flexi Pool: Work any time flexi pool initiative being created to allow employees to work hours that sit outside usual shift start times and lengths. We have significant internationally educated nurses recruited this year, with many arriving and OSCE support to enable registration for the winter. Implementation of pastoral app (InterN app) which will support development, pastoral care and onboarding. System wide IR Career Coach supporting development of IEN's to progress and enable them to upskill into senior roles. 28 RN's promoted to B6 & B7 roles ready for winter. The ICB has implemented a bank contract to enable staff to work across the system and provide support to winter	Bedfordshire Hospital has an up to date cross-site interprofessional standards signed off by all teams across both sites. Robust monitoring is in place on occupancy rates, with Bedfordshire hospitals setting a local trajectory of 80% bed occupancy on a Friday, ahead of the weekend. BHT is 3rd in the region for the 4-hour standard, with 76% performance. The Luton site are undergoing a significant restructure in their ED, to increase capacity. This has had an impact on ambulance handovers but will improve ambulance performance by winter. A new initiative has funded to embed the 15min handover measure by increased clinical workforce to streamline handovers, alongside the HALO. L&D are one of the top performing Trusts against the 12-hour journey time standard. There is a BCA workstream in place to embed senior clinical decision makers in ED, to improve their 4-hour standard and deliver criteria to admit to improve flow, whilst utilising admission avoidance pathways Across Bedfordshire hospitals the ambition is to reduce the

	pressures where required. Our Primary Care colleagues have a Flexible Staff Pool in place for all Practices to utilise, currently onboarding additional Advanced Nurse Practitioners and Practice Nurses In depth work with PCNs to consider Winter pressures when recruiting to ARRS workforce plans has been undertaken. Maximising utilisation of ARRS funding across all PCNs, considering innovative employment models and recruitment at scale to overcome challenges of supervisory capacity and estates constraints support our winter pressures. Primary Care CPD programme is prioritising training to support with Winter pressures e.g., Imms & Vaccs, Spirometry & COPD. We are also bolstering Care Navigation capacity and increasing number of Personalised Care Roles to maximise community assets e.g., Citizens Advice Bureau hosting Social Prescribing Link Workers BLMK has an AD lead for prevention who is responsible for the Covid and flu vaccination programme, which is overseen through the ICS wide Strategic Vaccination Board. We have plans in place for flu and Covid delivery that have been submitted and accepted by NHSE Eastern Region. Through our established programmes and strong EPRR systems we have a demonstrable history of rapid response and maintain this capacity.	number of days between the discharge ready date and the date of transfer out of hospital to an average of 24 hours for all but the most complex of patients. System partners have re-designed and simplified processes across Pathways 1 &2 which is underpinned by the BCA improvement plan, with the aim to implement by October 2023. VCSE partners are supporting through winter planning by enhancing discharge services. The BLMK system partners have modelled the workforce requirement for staff to be able to deliver as part of the integrated workforce planning undertaken with local and regional colleagues. As a system we are ahead of the trajectory for the 50K nurse recruitment ensuring the required level of staffing can be supported. This is supported through our Head of Safer Staffing who works with our Partner organisations to ensure actions can be taken to support demand and delivery. Between June 2022 and May 2023, there were 751 Nursing starters across BLMK. The system has undertaken a collaborative recruitment campaign to fill the vacancies within the HCSW workforce, including considerations for workforce required to deliver services throughout Winter. System partners have engaged in the collaborative campaign including Acute Trusts, Social Care and Primary Care. Early evaluations are showing

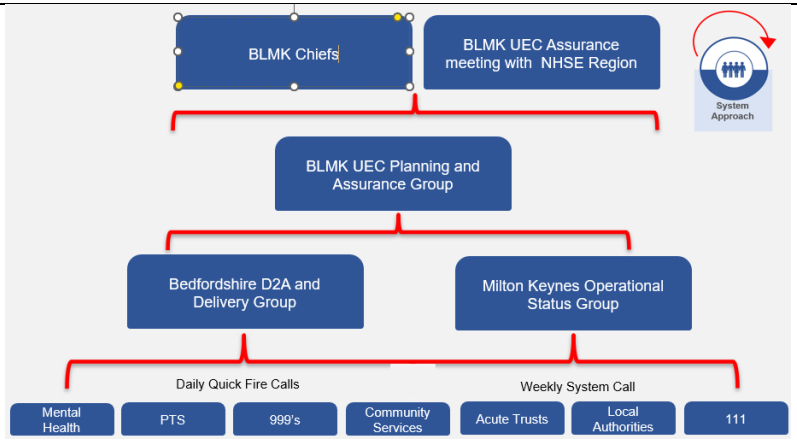
		significant increase in applications and shortlisting within our acute providers. Further attraction campaign for non-registered staff in the community with council and AHP partners planned for end of September which will support winter supply. To support retention of the workforce across Winter the ICS have implemented Legacy roles and have eight legacy roles in the system, exceeding numbers across the EoE region. BHFT and MKUH have the 'pool' which provides flexible hours to staff Minimum of 6 and 4hrs shifts worked (respectively) The Nursing & HCA pool gives staff the opportunity to secure a permanent role to fit in with school drop off post but with the ability to choose their hours and shifts and self-roster. We have significant internationally educated nurses recruited this year, with many arriving and OSCE support to enable registration for the winter. Implementation of pastoral app (InterN app) which will support development, pastoral care and onboarding. System wide IR Career Coach supporting development of IEN's to progress and enable them to upskill into senior roles. 28 RN's promoted to B6 & B7 roles ready for winter.

		The ICB has implemented a bank contract to enable staff to work across the system and provide support to winter pressures where required. Our Primary Care colleagues have a Flexible Staff Pool in place for all Practices to utilise, currently onboarding additional Advanced Nurse Practitioners and Practice Nurses In depth work with PCNs to consider Winter pressures when recruiting to ARRS workforce plans has been undertaken. Maximising utilisation of ARRS funding across all PCNs, considering innovative employment models and recruitment at scale to overcome challenges of supervisory capacity and estates constraints support our winter pressures. Primary Care CPD programme is prioritising training to support with Winter pressures e.g., Imms & Vaccs, Spirometry & COPD. We are also bolstering Care Navigation capacity and increasing number of Personalised Care Roles to maximise community assets e.g., Citizens Advice Bureau hosting Social Prescribing Link Workers BLMK has an AD lead for prevention who is responsible for the Covid and flu vaccination programme, which is overseen through the ICS wide Strategic Vaccination Board. We have plans in place for flu and Covid delivery that have been submitted and accepted by NHSE Eastern Region. Through our established programmes and strong EPRR systems we

		have a demonstrable history of rapid response and maintain this capacity.
Primary Care	Primary care access recovery (003).pptx We have daily primary care (all primary care activity not just general practice) activity reporting in place. There are clear escalation routes from practices/PCNs to our aligned ICB place teams in the event of capacity/resilience challenges in general practice. Flexibility is continually utilised to ensure that enhanced access supports capacity appropriately. The ICB will utilise the primary care winter allocation to stand up additional same day primary care capacity across primary care providers – as we did last year through ARI Hubs – the focus this year will be 'same day primary care', so broader pathways to ensure maximum utilisation of the additional same day capacity. All PCNs have proactive care initiatives in place for identified cohorts, these have been mapped and are supported by practices and additional roles and also have collaborative support from stakeholders established through integrated neighbourhood working. There are ICB and place based specific comms in place to illustrate the primary care / general practice offers. Further work continues to develop joint working between practices/PCNs and community pharmacies led by the ICS Community Pharmacy Clinical Lead	
Children and Young People services	<u>High-impact interventions for children and young people:</u> Paediatric Virtual Wards being piloted at Bedfordshire Hospitals, with interest also expressed at Milton Keynes Hospital (to be further pursued once resources identified). <u>Whole-system planning:</u> Whole-system CYP planning group (with representation from all providers and key stakeholders) has begun winter planning. ICB sighted on ODN planning for increased Level 2 PCC capacity. Key activity datasets established and routinely monitored.	

	<u>Paediatric critical care surge planning:</u> Acute trusts liaising as appropriate with their relevant ODNs regarding surge planning and mutual aid. <u>Mutual aid:</u> Importance of protecting paediatric elective capacity has been highlighted as part of current winter planning (drawing on experience of previous years). Ongoing winter planning will include co-ordination of individual provider escalation plans to ensure coherence. <u>Vaccination uptake:</u> Vaccine programme identified as a key strand of wider CYP winter preparations and included in winter planning activity. Includes Covid, Flu and MMR. <u>Supporting self-care and management of minor illness:</u> BLMK Healthier Together health information website established and continually developed. Communications planning underway to promote this and other health information to young people and families.	
Community Trust and Integrated Care Providers	MKUH hold weekly LLOS meetings with system partners to progress patients out of hospital and agree next steps. There is an improvement workstream committed to reducing LLOS which is inclusive of our commissioned community Seacole beds. A proposal for a new MK Integrated Discharge Hub (IDH) has been developed, to be physically located at MKUH to assist patients to navigate services both admission avoidance and discharge. There will be enhanced hours and an expanded team. The aim is for the Hub to be operational	The BCA is developing an integrated discharge team and board round standards have been set and agreed, these will be in place by November. This will tackle variation across wards to embed best practice. Patient pathway will be identified at board round and discharge ready date set. Identification of palliative/fast track/ EOL patients will trigger complex planning involving relevant services. As the Bedford site this is mitigated, there is a daily triage call, with system partners to discuss each patient, agree

	by late Winter 23-24. There are daily conference calls in place to discuss each patient, agree their pathway and discharge requirements. The integrated discharge team are embedding Criteria to Admit with agreed rehabilitation goals prior to admission to a commissioned community bed, which is communicated to both patient and family. Therapy resource is being reviewed to ensure there is appropriate provision in all commissioned beds to achieve a reduction in LOS and improve patient outcomes. As part of the development of the Integrated Discharge Hub a workstream is to be set up to focus on admission avoidance. ED already have input from the Frailty Team and streaming to MKUCS is in place. Use of VCSE to support patient turn-around and keep well at home. 2 admission avoidance beds are available at WICU. The weekly MK OSG and MK ISF group ensures there is joint leadership and system arrangements in place across partner organisations to ensure shared decision making and governance arrangements.	their pathway and discharge requirements . On the Luton site there 2/3 weekly (depending on demand) PTL to discuss and plan for patients The Luton site have a high daily discharge rate with a integrated discharge team. There are challenges around P2, intermediate care beds which impacts NcTR numbers. A review of existing contracts is being undertaken to support the care homes to accept patients in a timely manner to reduce spot purchases. There is a BCA improvement work plan across all pathways which includes embedding an integrated discharge team at the Bedford site and to enable the Acute discharge officers to plan and manage all discharges. This will allow community providers to have 'pull' approach to facilitate flow. Across both 'discharge ready' date is being embedded and work is being undertaken to ensure accurate reporting as per National requirements The integrated discharge teams are embedding Criteria to Admit with agreed rehabilitation goals prior to admission to a commissioned community bed, which is communicated to both patient and family. Therapy resource is being reviewed to ensure there is appropriate provision in all commissioned beds to achieve a reduction in LOS and improve patient outcomes. LA's and Community partners provide resource into admission avoidance pathways to ensure patients have



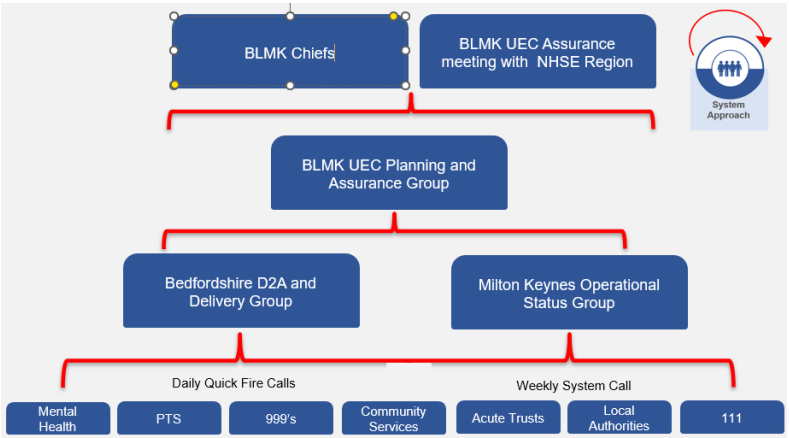
MK have E-Care which is a shared system for all partners to enable to discharge planning rehab/recovery plans to be shared and reviewed to streamline pathways and reduce duplication.

BHFT and MKUH have the 'pool' which provides flexible hours to staff Minimum of 6 and 4hrs shifts worked (respectively)

The Nursing & HCA pool gives staff the opportunity to secure a permanent role to fit in with school drop off post but with the ability to choose their hours and shifts and self-roster.

The ICB has implemented a bank contract to enable staff to access to alternative services. This includes first response team with crisis intervention (linked to UCH), enhanced home recovery service and use of VCSE to keep patients well at home. In Bedford Hospital there is a workstream planned to develop the admission avoidance pathway to ensure all resources are utilised, referred to appropriately and that the clinical navigation team review all appropriate patients in ED and acute assessment beds.

Through the daily quick-fire calls and delivery group, there is joint leadership and system arrangements in place across partner organisations to ensure shared decision making and governance arrangements



The PHEW app provides all system partners with patient level detail to enable to discharge planning rehab/recovery plans to be shared and reviewed to streamline pathways

	work across the system and provide support to winter pressures where required. SHREWD in place to support daily oversight of capacity versus demand and blocks in service provision across all partner organisations. This allows flexible resource utilisation and to proactively forward plan for demand and support with flow. Local and Regional assurance meetings are in place to ensure continuous self-assessment of system maturity and progress against delivery of our winter plan.	and reduce duplication. PHEW is also directly linked to SHREWD and is used to support operational flow and to submit data to the community discharge sitrep BHFT and MKUH have the 'pool' which provides flexible hours to staff Minimum of 6 and 4hrs shifts worked (respectively) The Nursing & HCA pool gives staff the opportunity to secure a permanent role to fit in with school drop off post but with the ability to choose their hours and shifts and self-roster. The ICB has implemented a bank contract to enable staff to work across the system and provide support to winter pressures where required. SHREWD in place to support daily oversight of capacity versus demand and blocks in service provision across all partner organisations. This allows flexible resource utilisation and to proactively forward plan for demand and support with flow. Local and Regional assurance meetings are in place to ensure continuous self-assessment of system maturity and progress against delivery of our winter plan.

Ambulance Trusts (where the ICB is the lead commissioner)	SCAS ICB Lead chasing SCAS for the plan	<u>EEAST</u> Ensure a greater number of deployed hours on the road over winter in line with agreed recruitment and resourcing plans. Last winter, (the 4 months of Nov, Dec, Jan and Feb) we deployed a weekly average of 88k patient facing staff hours, peaking at 91k in the busiest week of the year. This year we plan a weekly average of 89k patient facing staff hours, peaking at 92k. Increase the clinical assessment of calls in every emergency operations centre to deliver the navigation and validation of Cat 2 calls, as well as increasing clinical input to Cat 3 and 4 calls. Category 2 calls will begin navigation from late September following a successful test earlier in the year. Being a new national initiative, EEAST's telephone assessment figures (hear and treat) will increase with the addition of these new patient groups. We plan to have 56 additional clinicians (145 operating by December, from 89 in April) undertaking clinical triage and further clinician input into category 3 and 4 patients will be provided from 6 urgent care hubs jointly run within ICBs. We have committed a number of EEAST paramedics to the urgent care hubs and we are finalising our recruitment for up to 24 EEAST staff to be deployed onto the hub rotas in

		October. Ensure efficient electronic processes are in place for the transfer of patients who do not need a face-to-face response to services more appropriate for their needs, including urgent community response, urgent treatment centres and SDEC. Note the responsibility for other parts of the system to maximise the number of cat 3 and 4 calls responded to by UCR and falls services. Processes were completed in May for the transfer of patients into urgent care hubs or access to the stack. Currently around 90 calls are passed per day of which 55 per day are successfully dealt with. Establish sufficient call handling capacity and finalise arrangements for the use of the 'Intelligent Routing Platform' in times of surge. We estimate we will have 239 call handlers including agency by December and we are continuing to recruit and train with an aim of reaching 330 call handlers. Ensure mental health professionals are embedded in all emergency operation centres ahead of winter. 4 mental health specialists have been recruited so far and are working remote. We aim to recruit a further 2 by December. These roles may remain remote, or EOC based, or potentially be deployed to one of the urgent care hubs depending on how their support can be best used.

		Use the ambulance auxiliary service when needed. EEAST will be happy to receive support from any national provision. We are particularly keen for the availability of this to be mapped alongside any hospital handover pressures.

Mental Health

Roles and Responsibilities	

Ensure plans are in place so that individuals know how to access mental health services with access to effective assessment and help in a timely manner and that crisis alternatives are in place to help reduce reliance on A&E (recognising that A&E is still an appropriate way of seeking help and people presenting with mental health issues also may have urgent physical health care needs). This should include making reasonable adjustments to pathways and therapeutic interventions for people with a learning disability and autistic people who seek mental health support.	• Community Mental health teams review of patient care plans to ensure appropriate plans in place should service user begin to experience a crisis. This includes details of:
	  ○ Crisis Alternates - MIND Crisis Cafes and crisis phoneline. We have commissioned MIND to also provide a CYP Crisis Sanctuary for young people building on their provision in Beds and Luton, which is due to go live in Autumn.
	  ○ Crisis Services - Trust Single Point of Access (24/7 phoneline), access to CRHTT and Hospital Liaison Team (A&E based). Street Triage service operates in the community also with Police to support patients with Mental Health as part of overall Crisis Pathway.
	• 24/7 crisis support via NHS 111 MH option with the introduction of peer workers to bolster attendance to crisis cafes.
	• Crisis alternatives via MIND BLMK will remain in place at the following locations – Bedford, Luton, Houghton Regis and Biggleswade
	• Services make reasonable adjustments for patients with LDA – providers have recently introduced Oliver McGowan training as a part of mandatory training, we support the national STOMP/STAMP initiatives and in MK specifically in the past year undertook a large programme of work around support MH patients with LDA and sensory needs. Neurodiversity Staff networks are in place to better support staff in understanding and adapting to meet needs.

Where individuals do seek help for mental health issues via A&E, ensure processes are in place for assessment and onward support, including adjustments to meet the needs of autistic people and people with a learning disability. Ensure there are clear escalation processes for A&E where there is considerable delay in receiving specialist support.	• 24/7 Psychiatric liaison services are available in all three acute hospital sites providing assessment of mental health needs, brief psychosocial interventions, care planning and signposting to ongoing care/services. HLT has clear pathways and processes in place with Crisis and Community services for onward support as needed. • Services ensure a timely response which is monitored as both a local indicator and also in terms of national targets. • Intensive support teams and LD nurses available to provide therapeutic care planning and on-site support to ensure the needs of people with autism and learning disability are met. We also have pathways in place to support young people with LDA. • We also have a long-established LIST team in place in MKUH A&E, which again ensures timely response and is monitored with MKH hospital as both a local indicator and also in terms of national

	targets. • Escalation plans in place and communicated with acute trusts where there are delays in access to MH support. there are infrastructure risks in Bedfordshire that limit crisis response - delay for Bedfordshire MH hospital, and lack of overnight crisis accommodation in the county. We are pursuing both with support from the LA's, but these present material gaps this winter which will be supplemented by OOA inpatient placements
Mental health, learning disability and autism services should ensure maximum uptake of vaccinations for their populations, both inpatient and community. This is vital given the high incidence of COPD and other co-existing long-term conditions such as diabetes which can compromise response to flu and Covid-19.	• Flu Vaccination programme offered across each provider, led by infection and prevention control teams, including vulnerable patients on the inpatient teams. Initial communications have started being issued in preparation for this and will cover staff vaccination as well as support to patients (inpatient and community). • IST team lead on vaccination programme for service users with a learning disability. • We are used to supporting mental health patients as a priority group for vaccination, particularly in light of the work we do around physical health and health inequalities.
Ensure tools are in place to understand demand, activity, workforce and capacity in mental health provider pathways. This should be shared across the system to give a comprehensive view of mental health pressures and where support may be required that could alleviate pressure on both mental health and UEC pathways.	• Daily bed huddles in place to take stock of flow, demand and capacity. This is underpinned by up-to-date reporting on current bed state to maintain direct sight of status at all times from ward to board. • Head of patient flow attends daily quick-fire system call to share with wider Acutes and ICB colleagues. • System in place to step up multi-agency escalation calls to daily when system is heading into OPEL 3 • Additionally, we consistently monitor capacity, waiting times, referrals, vacancies access targets etc across all services including community as a part of business as usual. • Working with GIRFT to implement best practice approach to ensuring capacity support crisis prevention in the community. Ensuring the use of GIRFT optimising flow metrics are included in a BLMK UEC dashboard
Ensure access to emergency housing funds to enable discharge of patients with no fixed abode (NFA) to ensure that they can be supported with follow up crisis / community care and support.	• We work with partners to support patients with NFA and have processes to escalate particular cases for resolution, but further development needed here to access this funding to ensure it's robust as we head into winter. • Currently access for emergency housing via Emergency duty team out of hours • We have a challenge of cumulative patients delays in Luton (social housing for patients awaiting discharge from MH IP; delays at L&D for patients awaiting MH IP bed. ELFT are leading a

	professional / clinical review of how best we optimise management of clinical risk across these associated pathways. • Where alternate solutions are required, we have access to step down provision to support flow.
Lead delivery of actions from the NHS Long Term Plan and Delivery Plan for Recovering Urgent and Emergency Care Services that support winter pressures, particularly: strengthen ambulance response to mental health by deploying multidisciplinary professionals to support 999 mental health demand and preparing for the rollout of mental health response vehicles.	• Crisis Transformation work going on across CNWL and LEFT • BLMK has recently created the new UEC Board with system partners to oversee all crisis pathway transformation and developments and co-ordinate into a single place. • Mental health street triage in place which offers a multiagency response via 999 with Police, MH professional and paramedic and has reduced and sustained low levels of inappropriate S136s. This is being reviewed as a part of Right Care Right Person • Nurses in post in Police force control room to provide MH expertise and response via 999. • In Beds and Luton, we will be supporting the development of MH professional in EEAST control room to support winter demand. CNWL (Milton Keynes) also provide resource to triage SCAS Mental Health calls on a small pilot basis, to reduce inappropriate conveyancing. • BLMK ICB and providers are actively looking at adapting the ambulance response in future and with the new mental health response vehicles.
Optimising flow through mental health inpatient settings through system-wide focus on reducing delayed discharges and avoidably long length of stay in mental health inpatient settings. Work collaboratively with social care and other system partners who play a key role in timely discharge.	• Focus on discharge and step-down capacity across the system, particularly in Luton. Arrangements for additional capacity are being explored ahead of winter 23/24. This includes supported accommodation to increase discharge capacity and a crisis house to support admission avoidance. • System wide integrated dashboard for UEC is under development and includes data from across system partners. The dashboard will support monitoring of system flow and capacity across UEC • Daily bed calls in place to review capacity and flow to maintain direct sight of status at all times from ward to board. This is underpinned by up-to-date reporting on current bed state. • MADE events to support flow and discharge. These are undertaken jointly with system partners.
Continuing to raise profile of all-age 24/7 urgent mental health helplines and other complementary crisis support services – including those for people with a learning disability and autistic people, such	• Availability of 24/7 mental health support via NHS 111 MH option – campaign for advertising crisis alternatives to take place ahead of winter. • As a part of our care plans for patients in crisis we make patients aware of the services we provide across our 24/7 crisis pathway, including crisis alternates, as set out above.

as intensive support teams, ensuring delivery of NHS 111 'select mental health option' and working towards crisis text line implementation.	• 111 Mental Health is not currently available across MK; however, a project group is live working on this and meeting the national deadlines for soft launch in December 2023 and full launch April 2024. In the interim though we have a 24/7 crisis offer across our Crisis Team, Street Triage, Hospital Liaison, Trust SPA and crisis alternates support through MINDs Crisis Café and crisis line. • Developed mental health access via BSL support arrangements in place for deaf patients, in line with national guidance (July 2023).	
Supporting children and young people with mental health needs in acute paediatric settings by adopting the new integration framework for systems to support children and young people with mental health needs within acute paediatric settings, and to take up NHS England (Workforce, Training and Education directorate) commissioned CYP crisis telephone training to support crisis mental healthcare staff. Maximise the uptake of training on learning disability and autism appropriate to their role, to ensure preparedness to be able to meet the needs of autistic people and people with a learning disability.	• LIST will go on to the ward at MKUH to support CYP. We have also commissioned Service Six to provide additional capacity for step down and support. We have established local partner calls with MKUH and Social Care as required to escalate patient flow issues for resolution. • The majority of our telephone response is by MK based clinicians in hours, out of hours they are directed to the CNWL SPA who access AMBIT training to support crisis response. • See above re reasonable adjustments	
Other things we are doing	• Crisis pathways review underway to improve flow and access • Development of business cases for crisis houses and walk-in assessment units. • Developing implementation schedule for Right Care Right Person • Development of UEC dashboard • £246k for Step Down Beds received via BCF/HDF to support flow and resilience. • CEN Pathway – we have adapted our services to support more CEN patients in Crisis/Community to ease pressures on Campbell Centre, which supports admission avoidance, discharge and flow. • CYP crisis sanctuary is due to go live in Autumn to provide a crisis alternate for CYP to A&E. • Linking with ELFT run CYP Intensive Support Team for BLMK, which is adjoined to Evergreen (T4	

	unit) and supporting CYP at risk of admission to be managed in the community.
Local Authorities and Social Care	Across BLMK social care have increased their intermediate care services, to provide domiciliary care, supporting timely and effective discharge. The BCF capacity and demand plans are a standing agenda item in the BCA and the MK ISF steering group. This ensures

	robust oversight enabling appropriate planning to take place. Milton Keynes are Developing a demand and capacity tool, with a go live date expected of 1st October of winter. Bedfordshire and Luton, have the PHEW app, which provides data regarding demand and capacity. Through developing our BCF and Discharge fund allocations, we have taken account of likely demand and capacity required across our social care market. By working collaboratively across the system as part of our improvement programme, we are assured that discharge management, including those with complex needs are identified early in their pathway and planned effectively to ensure improved patient outcomes, reduce LOS and readmission and systematically embed good practice. Winter surge planning is being scoped alongside our business continuity policies to ensure arrangements are in place for any surge and in relation to infection control requirements.
	BLMK Response
KLOE-1.4: How will the ICB lead the system through the winter period? • How will 24/7 oversight of system pressures through the System Coordination Centre (SCC) be maintained? • How will the ICB ensure the appropriate structures, systems and process are in place to maintain operational oversight and delivery? • How will executive level and senior clinical leadership be used to deliver a successful winter for the system?	SCCs will provide 7-day cover in-line with the regional/national operational model between 0800 hrs and 2000 hrs. During OPEL 4, or as deemed necessary by the ICB SRO (or equivalent), in consultation with the SCC room lead, the SCC should review and extend its cover to ensure a proportionate response to the level of operational challenge or clinical risk. The SCC must function during the core operational hours as a **single point of contact (SPOC)** for local system and NHS England regional stakeholders in line with the defined scope of the SCC. This will include the availability of a SPOC mailbox that can be accessed by SCC staff. **Proposal** It is proposed that the SCC function within BLMK is split across Bedfordshire Care Alliance and MK Place and the ICB core team in order to meet the required operational standards. Management of system flow, pressures, utilisation of capacity and mitigations should happen as close to local partners, clinicians and decision makers as possible via alliance and place.

	The ICB will ensure strategic system oversight and escalation of issues and reporting to NHSE on a daily basis. **BCA/MK** **Improved visibility of operational pressures** Senior operational and clinical leaders will have an aligned view of the operational pressures and risks across system providers which should support collective action to improve patient safety. **Real-time co-ordination of capacity and action** A system view of capacity across all providers and the wider health care system, leading to a collaborative effort to improve performance to patients' benefit. To identify predictable and emergent activity to support forward planning and data will be visible to all key decision-making and co-ordinating personnel. • A consistent operational cadence that factors in meetings with ICS partners in alignment with the OPEL Framework and local policies • Relevant demand and capacity planning data, including forecasting tools to support with pre-emptive operational planning. **Improved clinical outcomes.** Coordination and leadership at the local level to oversee a suite of operational metrics in real time enables it to provide a timely response at a system level, assisting local providers to deliver the right care at the right time. **Roles and responsibilities** • During operating hours, a senior member of staff will assume the role of SCC lead (or equivalent). This role adopts day-to-day senior decision-making and will ensure the SCC is delivering the operating protocol to full effect. The SCC room lead is responsible for the oversight of system capacity, demand and escalation across the Alliance/Place. This includes reporting to the ICB on prospective and actual deployment of system protocol or exceptional intervention during this time. • Depending on the size and complexity of the alliance/place, the number of personnel and skill-mix required to

	support the SCC room lead will be dictated by the Place/Alliance but should represent the partner agencies within the system. This should also include an operating structure that enables input from senior clinicians. This is to ensure that there is clinical insight to planning local action and co-ordination of mitigation in response to pressure in the UEC and wider pathways. • SCC staff should be trained to optimise the utilisation of local digital solutions, real time data* and other related reporting systems. • Systems and processes in place to co-ordinate and manage returns to regional and national teams – ensuring that returns (including SitRep returns) are accurate and provided in line with timelines and the Capacity Tracker is completed, including for community-based. • The SCC will be required to develop and maintain a Standard Operating Protocol (SOP) that defines its function and key deliverables. This will be reviewed on an annual basis. • The SCC Alliance/Place will provide a handover and action plan to the ICB, at a specified time daily, including ICB On Call who will assume responsibility for system oversight out of hours. **ICB** The SCC is a constituent part of the ICB and, as such, should facilitate collaboration within the system through its operational leadership. An identified executive-level member will be accountable for the SCC at ICB Board level, ensuring **co**-ordination across the system using a shared framework of escalation policies including the OPEL Framework 2023/24. The executive member will be supported by a senior responsible officer (SRO) or equivalent who will lead the business planning and strategic oversight of the SCC. The ICB will support the SCC in developing a reporting. This would include a set of local metrics and would cover frequency of reporting. Where relevant, due consideration will be given to: • All parameters outlined in the OPEL Framework 2023/24. • Emergency Care 4-hour performance. • Category 2 ambulance response time. • Time of Arrival to 12-hour delays.

	• Length of Stay (7, 14 and 21+). • No Criteria to Reside % or other appropriate discharge metric. The SCC will be required to develop and maintain a Standard Operating Protocol (SOP) that defines its function and key deliverables. This will be reviewed on an annual basis. **Protocols will include:** • **Local provider surge protocol (or similar)** that seeks to maintain the timely flow of patients through the emergency department (ED), mental health, community settings and other parts of the health system. • **Protocols covering ambulance conveyance and handover pressures (or similar)** that ensures an effective response to increased pre-hospital demand and/or an incident that requires specialised resources to manage it. This may also cover the role of SCC in ambulance diverts. • **Protocols covering access to mental health inpatient services (for all ages) or similar** that would specify system actions to mitigate risk of exceptional patient waits, heightened clinical risk and poor patient experience. • **System communication policies or similar** that would cover the interface between the SCC and the ICB Communication Team. Enabling patient choice or providing guidance to the public during critical events or dates should be a key aim of a joint communications plan. • **Inter-hospital transfers or similar** that would cover the role of SCC in monitoring, actioning and escalating cases of patients awaiting specialised care or return to local hospital in excess of provider or tertiary agreed local thresholds. The SCC would be expected to escalate delays to the region at 72 hours and request national support via the region at 96 hours. • **Incident management including EPRR**, ensures that the role of an SCC is outlined in the ICB Incident Response Plan and describes how it will provide real-time data and system intelligence to the Incident Co-ordination Centre (ICC). • **Protocols covering escalation of primary care pressures** that seek to ensure patients who can be treated in primary care remain in primary care. A consistent operational cadence that factors in meetings with ICS partners and regional NHS England teams in alignment with the OPEL Framework and local policies. Systems and processes in place to co-ordinate and manage returns to regional and national teams – ensuring that returns

<table>
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<td>(including SitRep returns) are accurate and provided in line with timelines and the Capacity Tracker is completed, including for community-based beds.

Required Operational Standards (ROS) for SCC operations.
<table>
<tr><td colspan="3"></td></tr>
<tr><td>ID</td><td>Requirement</td><td>Section</td></tr>
<tr><td>SCC – PE 1</td><td>SCC has identified board-level executive member and is supported by a Senior Responsible Officer (or equivalent).</td><td>4.2</td></tr>
<tr><td>SCC – PE 2</td><td>SCC has sufficient resource to deliver day-to-day function in line with national operating model between 0800 & 2000 hrs.</td><td>5.2, 5.3 and 6.2.6</td></tr>
<tr><td>SCC – PE 3</td><td>The ICB will ensure that they either have SCC room leadership with active clinical registration (GMC, NMC or HCPC), or an operating structure that enables input from senior clinicians in the ICB</td><td>5.4</td></tr>
<tr><td>SCC – PE 4</td><td>SCC Director on-call cover is in place between 2000 & 0800 hrs.</td><td>5.5</td></tr>
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<td>KLOE-1.5: Infection Prevention and Control (IPC)

• How have IPC colleagues been involved in the development of the system Winter plan?
• What plans have been put in place</td>
<td>BLMK Response
IPC colleagues have been involved through arranging attending and facilitating place-based winter planning meetings. Meetings have been held so far in May, June, July and August 2023.
I. These meetings have been attended by representatives from care homes, local authorities, acute trusts. Some members missing from the group such as Extra Care/Domiciliary schemes. Transport. Primary Care. Residents. GP’s. Families. Healthwatch. Care Essential. Social Prescribers. . ELFT MH/LD have been invited to attend the follow up meetings.</td>
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to promote optimisation of IPC practices and effect Healthcare Associated Infection (HCAI) prevention/reduction in hospitals and community care settings? What support has been put in place at a system level to, ensure IPC provision to care homes and step-down intermediate care facilities in preventing and reducing infection transmission, and aid capacity to discharge patients?	II. The 1st meetings across the places focussed on what has worked well and not so well in the last winter. Competencies and challenges were explored. III. Quality improvement lead and coach was brought in to facilitate and lead a quality improvement project. The project was formed with a few members chosen across the different areas to form a working group and feed back to the core group their discussions. IV. Key themes were explored including discharge process, communication and system pressures. V. A QI project titled Right time, Right care, Right place for our care home residents has been started in the second meeting. VI. The main aim of this meeting was to give an overview of the last care homes workshop and detail the next steps in the journey. VII. Project team structure and responsibilities and journey for improvement were discussed. VIII. A follow up meeting will be arranged. IX. In the meantime, the QI project group continue to meet and will feed back at the next core group. The date and time has not been circulated. To promote optimisation of IPC practices and effect health care Associated Infections prevention and reduction in hospitals and community care settings, the following plans has been put in place: I. Improve surveillance and support system wide actions to reduce and prevent HCAI's through analysis of reports, supporting system wide actions and taking part in assurance visits. II. Increased visibility and raising awareness of the team across BLMK to support and gather assurance. III. Keeping up to date with changing patterns across the system and nationally in IPC education. Providing guidance and education as required to all relevant providers. IV. Supporting Primary care leads with use Infection Control Audit Tool (ICAT) through analysis of reports and establishing trends. In supporting care homes and step-down intermediate care facilities, System Escalation Care Home Cell meetings continue to be held in collaboration with local authorities' partners to discuss any issues affecting discharge flow as and when required.
KLOE-1.6: Support for care homes	Care homes across BLMK are supported via a number of community-based services: Rapid response, GP practices, LA teams. The BLMK QI care home team are in regular contact with homes and provide support/guidance and outline

• What is the overall offer to care homes in supporting residents to remain well, access timely support, care, treatment, and advice and to remain in the care home for their care and treatment wherever possible avoiding unnecessary hospital admission.
• The recommended roles and responsibilities for each part of the system detail several areas which should support care homes and care home residents – specifically how will care homes be supported through both a proactive and reactive care approach across the following areas:
  ○ Enhanced health in care homes
  ○ Personalised care and support planning
  ○ Oral health
  ○ Falls prevention exercises
  ○ Vaccination and immunisation – staff and residents
  ○ Remote monitoring
  ○ Urgent community response (including falls response)
  ○ Provision of enhanced clinical support 2000-0800
  ○ Virtual wards
End of life care planning
	networks available to care homes as required. BLMK medicines management teams are allocated to cover specific areas across BLMK care homes. Regular visits and education are provided to support these areas.
	Vaccinations: Actual cohorts and programme dates are not yet confirmed; however, current expectation is that the Autumn programme will likely run from 04/09/2023 to 17/12/2023 with just Care Homes being done in the first two weeks. This will also coincide with the Flu programme so opportunity for co-administration.
	Delivery models will be from local vaccination sites i.e., Community Pharmacies (CPs) and Primary Care Networks (PCNs)
	
	Falls Prevention Exercises & Urgent community response (including falls response)
	• Bedford Hospital Falls Service Physio led, now MDT, consultant, OT Single point of access, triage, assessment and intervention Range of strength and balance programmes,
	• BBC First Response Service (Central Beds) Falls support workers, assessment at home following clinical assessment, equipment, advice, onward referral, telecare, continence, handyman, reduce risk. New pathways, 50 referrals pm
	• Urgent Community Response – CCS are providing Falls service running until 8pm on weekdays, Assessment and Maga Chair lifting Equipment. (Central and Beds Borough)
	• Bedfordshire Fire and Rescue Service Falls Response Prevention team, trained by EEAST, clinical triage by EEAST, model rolled out across region. Home safety checks in collaboration with ELFT clinicians
	• EngAGE – isolated older people, care homes, supported living Falls prevention in Care homes with Virtual exercise sessions for care homes.
	• Falls prevention awareness champion in care homes.
	• Raizer chair implemented in 75% of care homes across BLMK.
	• Home First/ Rapid Support. Willen Hospice Help/Advice Line.
	
	EHCH:
	Collaborative training Framework looking at setting up training and champions for the areas of the ENCH Framework with recognised passport of training. Ongoing work which includes al parts of the framework

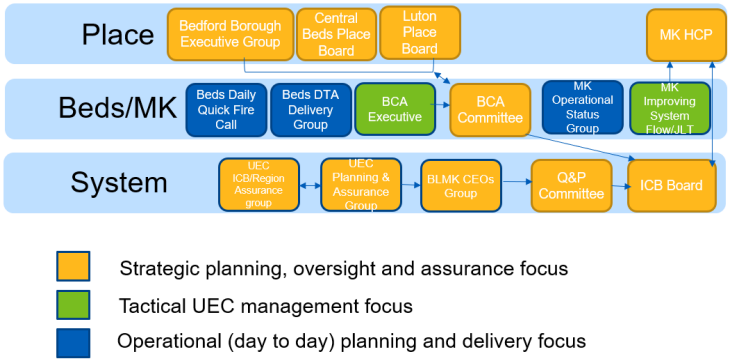
	Oral Hygiene: Study days for care homes have included oral hygiene. Several local projects aimed at enhancing this aspect of care have been running since Dec 2022 **Remote Monitoring: Information Provided by Digital Leads for BLMK.** Acoustic monitoring being offered to homes, Raizer chair and whzan and NHS emails and proxy access. Reporting to digital leads when not found in homes. **End of Life Care Planning:** • Keech Hospice Free Education programme • Syringe Driver Training Community services • Referral for support by Care Homes to St Johns Hospice. • PCNs introducing Palliative Care Support Nurses. • Mac Millan Services Support available throughout the year from Hospices. Rapid response doesn't increase for winter. **Personalised care and support planning** This is monitored by the LA's and the QIN support visits.
KLOE-1.7: Christmas and New Year • Outline the steps, including commissioning actions, that are being taken or planned to ensure core services remain accessible to the public over the Christmas and New Year period – specifically between 18 December 2023 and 8 January 2024 in responding consider at a minimum:	The UTC's, Putnoe WiC and UGPC will be open as per their contracts so: MK UTC open 24/7 including all Bank Holidays Bedford UTC open 08:00 to 24:00 every day including weekends and Bank Holidays Luton UTC open 08:00 till 20:00 every day including weekends and Bank Holidays Putnoe WiC open 08:00 till 14:00 weekdays and 08:00 till 17:00 weekend and Bank Holidays Luton Urgent GP Clinic open 08:00 till 23:00 every day including weekends and Bank Holidays. GP Practice opening times:

○ General practice ○ Dentistry ○ Community pharmacy ○ Specialist helplines ○ Hospice support	Sat 23rd, Sun 24th, normal weekend close but open for enhanced access if applicable Mon 25th, Tues 26th, normal bank holiday closes Wed 27th, Thurs 28th, Fri 29th, Open as normal 8.00 – 6.30pm Sat 30th, Sun 31st, normal weekend close but open for enhanced access if applicable Mon 1st Jan – normal bank holiday close Tues 2nd Jan onwards – normal opening hours. Mental health services are available 365/yr and they have planned provision for staff cover over the Christmas and New Year period. Our 24hrs services will function as normal, this includes inpatients services, PLS, CRHT, MHST and NHS 111 option 2. Dental contracts it is dependent on their contracted hours which can vary by contractor, and some may cover bank holidays. the route for emergency dental care is via the 111 service, dental triage and if need to be seen via the on-call urgent dental contractor. Pharmacy opening hours, there is a national process and timeline whereby pharmacies declare their bank holiday opening hours on the DoS. declarations. Our Pharmacy and Optometry team will review the declarations to ensure there is adequate provision (if not, there are regulations that can be applied). The team will map the opening hours across the ICB footprint and share with the ICB and Local Pharmaceutical Committee to confirm the cover before releasing the final list that occurs circa 4 weeks before bank holiday period. MK- Palliative Care Community hub and BCA - Specialist hubs are in place across 24hour advice and support offered 365 days per year for patients, relatives and carer but requires additional workforce to be sustainable and meet demand.

KLOE 2: high-impact interventions

Key question and points to consider	BLMK Response
KLOE-2.1: How will your choices to implement the high impact initiatives from the UEC Recovery Plan support you to achieve the required 4-hour Cat 2 ambulance performance over winter? As per the Universal Improvement Offer, you have submitted self-assessments against all 10 high impact initiatives and have identified 4 of the high impact initiatives to prioritise ahead of winter. • Are there other high-impact interventions relevant to the system that are being prioritised? • Are there robust plans in place to make a material impact on these interventions ready for winter? • How will the system monitor progress against these interventions? • What executive leadership for priority interventions is in place?	Four key areas were highlighted for BLMK which required further development, these being: – **Same Day Emergency Care (SDEC)** SDEC will support the reduction in admissions, – **Community Bed Productivity and Flow (WICU and Archer)** Robust bed management and maximizing the utilisation of community beds, will accommodate patients that are 'medically fit' to leave the acute hospital, but requires further support before returning to their place of residence. – **Acute Hospital Flow Ward Processes** Ensuring all patients have a proposed discharge date, allows all teams involved in the patients care to start planning for discharge before they are medically fit. Ensuring Internal Professional standards are fully implemented. Ensuring 7 day a week board rounds are in place. Weekend discharges to maintain flow. Senior Clinical Decision Maker in place 7 days a week - **Urgent Community Response** To provide a rapid response in the community which will help divert cases away from the Acute and ensuing the patient receives the right care, first times. To provide external stacks for patients to be passed to a wide range of alternative providers at the point of call and introduce 'call before convey' via single point of access hubs in each ICS for all non-life limiting Emergencies to provide lowest acuity care required. Whilst we need to review the results of the HII self-assessment and ensure we are working to address these in line with the national requirement, there are other critical issues in BLMK which are not necessarily highlighted in these metrics. These include:

	Use of escalation / surge beds in acute (elective) clinical settings Spot purchase of intermediate care beds and any under-utilisation of commissioned beds Delays transferring patients who are non-CTR into onward pathways. Workforce challenges affecting home care provision in some Boroughs Urgent (same day) capacity pressures (whilst HII assessment includes SDEC, need to understand same day pressures across the system Step-down accommodation and crisis (overnight) capacity for mental health (all ages) To ensure we are focussing on delivery in all key areas it is proposed that we develop a single, co-ordinated oversight of UEC pathways (including winter readiness) to Provide peer assurance on winter readiness and escalation actions. Agree provider collaborative review / oversight and how these feeds into ICB / regional reporting. Shared oversight of residual risk, and options to minimise (including gaps in UEC provision) Single source of the truth – co-ordinated reporting to minimise duplication of assurance to NHSE etc (dashboard included in separate paper) Develop and agree key actions to be taken to address challenges and preparedness requirements. Process and Timelines **28th July** – self assessment against NHSE UEC Recovery High Impact Actions submitted to NHSE (BCA and MK Together) **August** – winter readiness self-assessment completed (includes focus on local issues and Flow / Intermediate Care Pathway programme plans) **Early September** – ICB peer review (critical friend) of self-assessment by each Provider Collaborative **6th September** – National ICB Chairs event – winter readiness to be reviewed – briefing required for ICB Chair **11th September** – submit overall surge and winter plan to NHSE – template and process/timeline expected soon

	29th September – winter assurance presented for ICB Board review. **6th October** – Deep Dive Winter Assurance by ICB Quality & Performance Committee 
KLOE-2.2: How will the system ensure adequate improvement capability and capacity is in place to deliver on the high-impact interventions? • How many Recovery Champions have you identified? • How will Recovery Champions be supported to develop their improvement capability? • How will Recovery Champions be supported to commit sufficient time to the priority interventions? How will you make use of the full range of support	Seventeen iUEC Recovery Champions were identified following the iUEC pathway maturity self-assessment. They have been attending a programme of generic taster sessions as well as a series of Core Learning Events as part of the Universal Support Offer – Building Improvement Capacity Module between August and mid-September. The BLMK ICB System Lead has nominated Recovery Champions onto the national workstream modules for Delivering IUEC improvement for the 4 High Impact Intervention priorities from the maturity self-assessment outcome, that will commence on 11.09.23. The availability of support needs to be reviewed in terms of line management capacity and from appropriate role models / mentoring programmes.

available to all organisations in the system through tiers 1 and 2 where relevant and the universal support offer?	Recovery Champions will need to be released from their normal duties to attend the programme, which is flexible as modules are held virtually and recorded on MST. Use of the full range of support, resources, and activities available could be made via the learning lab hosts and by cascading information through regular briefings and updates and providing access through MST shared folders to all organisations across the system.

KLOE 3: discharge, intermediate care, and social care

Key Question and Points to Consider	Milton Keynes (MK Together)	Bedfordshire and Luton (Bedfordshire Care Alliance)
KLOE-3.1: What plans have been put in place to ensure effective joint working with relevant local authorities and social care? • Do care transfer hubs have clear line of sight to capacity challenges across intermediate and social care? • Do you have a named system lead for discharge across health and social care to facilitate joint management of risk over the winter period? • Are care transfer hubs fully operational with the relevant partners working together and reviewing all available data to deliver improvements? • How will you ensure that the Discharge Ready Date field is being comprehensively completed to enable the metric to be published before	MK City Council is a lead partner in the ISF governance structure and chairs the MK JLT. Social Care chair the ISF Core Project Group meetings and are involved in the ISFSG, MK OSG system calls and the RTTL conference calls. The local authority also inputs data regularly on SHREWD so that operational pressures can be monitored. Information on capacity challenges in the Community and Social Care is shared on SHREWD on a daily basis and via the MK OSG SitRep on a weekly basis, when a detailed multi-agency discussion of issues takes place. Regular MADE events are also held to expedite discharges and increase flow.	The BCA and Bedfordshire Delivery Group ensure joint working across Health and Social Care including community providers and VCSE. The development of the Integrated Care Hub will enable line of sight to capacity challenges across the system. Anne Brierley is the Lead for UEC A discharge hub is live with a paramedic, ED consultant and UCR teams. The Discharge Ready Date is for the Acute Trusts to complete. Daily Quick-Fire calls take place where escalation issues are discussed and actioned, ensuring mutual aid where available. Regular MADE events are also held to expedite

winter, and subsequently used to improve local services? What are the plans for escalation between the NHS, local authority, social care and VCSE providers to mitigate delays in discharging patients from general and acute and community beds over the winter period? And for step up / admission avoidance?	The BLMK ICB System Lead for UEC is Anne Brierley, Chief Operating Officer. The ISF Core Project Group has developed proposals for a new Integrated Discharge Hub that are currently being consulted on with a view to opening late winter 2023-24. The BLMK ICB SCC Standard Operating Procedure (SOP) outlines the escalation triggers, process, flow chart and battle rhythm for tackling OPEL changes. The Virtual Ward has 75 beds open including for step up / admission avoidance.	discharges and increase flow. The BLMK ICB SCC Standard Operating Procedure (SOP) outlines the escalation triggers, process, flow chart and battle rhythm for tackling OPEL changes. VW is performing against its trajectory step-up/admission avoidance capacity is in place across Health and Social Care.
KLOE-3.2: How will you meet any gap between demand and capacity identified in your Better Care Fund (BCF) intermediate care capacity and demand plan, or any additional gap as a result of demand that may occur over and above forecast levels: • All Health and Wellbeing Boards have submitted BCF demand and capacity plans for intermediate care (step up and step down) for 2023/24. At ICB level, is there an intermediate care gap between demand and capacity projected for the winter period (November 2023 - March 2024)? And is there an intermediate care gap in your Intermediate	As part of the MK deal and improving system flow project additional capacity is being commissioned to support pathway 0, the VCSE support with the existing provider Age UK. The additional support is now in place ready for winter 23/24. To improve productivity across the system the following will be in place for winter 23/24: Bridging Care service –this is anticipated to be ready for November 2023. Live in care – related to the delirium pathway to prevent delayed discharges due to the short supply of care home beds. Supporting people to return home, following the hospital admission.	Workshops have taken place across Bedfordshire to further develop work around demand/capacity planning and modelling with planning templates submitted to the BCF Board. Where gaps in capacity are identified bridging services have been commissioned. There are no plans to increase bedded care but rather enhance non-bedded intermediate care to support our Home First ethos. There is a Delirium Pathway in place across Bedfordshire providing live-in care for up to 3 weeks. Virtual wards are in place supporting admission avoidance. The North Bedfordshire Model currently being

Care level surge / super surge plans? • What are the plans to meet this gap through improving productivity, e.g., through reducing length of stay (in acute or community beds), or through reducing overprescription? Are there any further plans to meet this gap through increased commissioning of bedded and non-bedded intermediate care? If so, how much will this cost? Have these plans been developed with local authorities? • How well developed are these plans and will they be in place (agreed, commissioned, and provided) by winter? Have these plans been shared with local authorities to inform the refreshed BCF plans that will be required in October?	Same Day Emergency Care: - Linking in to the SDEC more widely with our work around Urgent Community Response (2-hour response for admission avoidance and supported discharge) and Virtual Wards. This is in place. Frailty: Virtual Wards is focussed on this. There is also wider work through the Improving System Flow group e.g., falls, end of life, therapies. Inpatient flow and length of stay (acute): We are in the process of developing our integrated discharge hub. Community bed productivity and flow: Discharge pathways 1 and 2 have been reviewed we will be adapting services to meet need, which will improve length of stay in community beds and intermediate care services. Our new care academy will also be focussed on a therapy led intervention and support, to maintain people in their own homes longer. Virtual wards: mobilised and increasing bed numbers and occupancy per national requirements. Focus in MK is on frailty, respiratory and cardiology and links across CNWL, MKCC and MKUH. The virtual ward also includes a Bridging Care service. Urgent Community Response: Historically had strong performance on the 2-hour response times on this already historically. Capacity has been added to the service, linked to Virtual Wards. Working with SCAS to trial Access to Stack to reduce ambulance conveyancing and manage	implemented will provide an Integrated Discharge Hub which will better enable demand and capacity planning and actively reduce identified gaps. The activity described above is in collaboration with acute, community services and the LA. All partners have been consulted on the plans.

	more patients in the community – pilot recently started and being expanded. Integrated Discharge Hub: This part of the improving system flow project, the plan is working towards implementation in late winter 23/24. There are no plans to increase bedded capacity across the MK place, investment is taking place across non-bedded capacity and virtual wards as detailed above. The activity described above is in collaboration with acute, community services and the LA. All partners have been consulted on the plans.	
KLOE-3.3: Community hospital and Intermediate Care capacity • What steps will you take to deliver an improvement in the average length of stay across your community hospital beds by March 24? • How will you improve Community Bed productivity and efficiency to maximise flow? What plans do you have in place to develop a therapy-led intermediate care service for people on discharge pathways 1 and 2 to be in receipt of the service in a timely way?	Community bed productivity and efficiency will be improved through: the Right to Reside Project, Community MADE, morning huddle / MDT to expedite discharge. New options for Pathways 1 and 2 are being developed for therapy-led intermediate care services.	The North Bedfordshire Model is being implemented to improve the average length of stay across hospital and community beds by March 2024. The North Bedfordshire Model includes plans to develop a therapy-led intermediate care service and meetings are currently scheduled to develop the therapy-specific plans

KLOE 4: H2 numerical submission

Key Question and Points to Consider	Response
KLOE-4.1: demand assumptions • Explain any revised demand assumptions that are captured in the template. Is there variance against demand assumptions for year to date.	2H UCR – Revised demand is based on actual performance over Q1 and 2, and associated activity growth in these periods. This is higher than our original activity plans submitted in May 2023. Due to increased actual demand over Q1 and 2, the forecast for Q3 and 4 have been amended accordingly. Revised figures show a total increase of 186 responses in Q3 and 185 in Q4 (total 371 additional for 2023/24). Community Beds – BLMK planned capacity is 135 beds and we have no plans to increase against our original plan.
KLOE-4.2: supply Explain any variance in supply against the agreed 2023/24 plan.	2H UCR - To add general context in terms of BLMK resource: • Patients are triaged and returned to the stack every month. Some providers have gained additional capacity/supply from various sources of funding which has begun to impact capacity levels.

KLOE 5: Escalation plans

Key Question and Points to Consider	BLMK
KLOE-5.1: Describe the system escalation plan • Using the anticipated non-elective demand scenario outlined in the numerical submission describe the point at which demand would outstrip the capacity profiled for surge and the steps that the system will take to respond to this.	BLMK ICB has reviewed its current escalation / surge plans against the new System Co-ordination Centre and OPEL framework published by NHSE in August 2023. BLMK ICB comprises of 2 almost completely distinct UEC geographies – MK with SCAS as the ambulance provider and Bedfordshire Care Alliance, served by EEAST ambulance service. Divert pressures usually originate elsewhere in the relevant ambulance region (South East and East of England) respectively, requiring the System Co-ordination Centre to engage equally across 2 NHSE regions.

• Specifically outline the consequences of this on other services. • Describe plans in place to expand adult and paediatric critical care capacity if needed? • Describe the whole system escalation plan including primary care, social care, and local authority. Describe how capacity, including capacity in high-impact intervention areas e.g., ARI hubs, will be expanded in the event that demand exceeds planned capacity.	Escalation on patients from outside BLMK Boroughs awaiting supported discharge packages also requires ongoing communication across several ICBs and NHSE Regions. Within our 2 BLMK UEC systems, each provider has committed to reviewing its internal OPEL 3 actions during September, with specific focus on: • Clarity on management oversight to optimise capacity and flow and manage individual patient / service escalations in a timely manner. • Internal challenge that actions identified quantifiably manage clinical risk along the wider UEC pathway, ensuring that limited actions from one provider do not leave disproportionate risks elsewhere in the pathway. • De-escalation plans are in place to recover from surge actions and return to BAU at the earliest possible opportunity. A review of co-ordinated OPEL 4 actions (MK Together, Bedfordshire Care Alliance and ICB) is planned for late September. This will be a peer challenge and co-production process to ensure that: • OPEL 4 actions are co-ordinated across providers within a local UEC system to optimise flow and reduce clinical risk. • De-escalation actions are clearly understood and communicated, especially to sustain elective activity as well as reduce clinical risk in UEC flow. • Communication between partners is sustained to optimise flow, including in the OOH period including with primary care and 111 partners. • Effective use of System Co-ordination Centre, especially for OOA issues, such as ambulance diverts from other ICBs, or patients delayed awaiting discharge support from providers from neighbouring regions. The current system escalation plan defines specific triggers and thresholds at which demand is expected to outstrip the capacity profiled in the numerical submission. These triggers are based on quantitative measures. Once these triggers are crossed, it signals the need to activate the escalation plan.

	Response Steps: When demand exceeds planned capacity, the system will respond with a coordinated set of actions, to include: Activation of Surge Capacity**:** Mobilising additional resources, opening up escalation beds, creating additional capacity in the community and increasing staffing levels Reassignment of Resources**:** Reprioritising and reallocating healthcare resources, such as stopping non-urgent patient caseloads, mandatory training calling in off-duty staff. Coordination across Acute site and other health/social care services by collaborating to share resources and patient load if necessary. Communication: Implementing a communication plan to keep the public, healthcare providers, and other stakeholders informed about the situation and any changes in service delivery. The consequences of diverting resources to address the surge in demand will lead to delays or rescheduling of elective procedures, outpatient services and community resource. Workforce moral and fatigue resulting in higher absence rates and therefore provisions, resulting longer wait times in critical services and a bottleneck in flow. Bedford Site: Pilgrim ward will continue to be used for higher level respiratory patients requiring NIV support with the critical care unit being used for patients under the care of an ITU consultant. Luton Site: If further capacity is required we can move NIV services from critical care onto the dedicated respiratory ward which will provide an additional 8 NIV beds opening on ward 10. Milton Keynes: We will review the ability for wards 15/16 to have enhanced levels of NIV BLMK: If additional capacity is required, the teams would look to transfer critical care patients via the adult critical care network. PCC ODNs (Paediatric Critical Care Operational Delivery Networks) are looking to expand capacity and

	we are included in those discussions as to where increased capacity would be most valuable. The system escalation plan is not limited to acute care facilities but includes primary care, local authority, community and voluntary care. The plan details how these various components of the healthcare system will coordinate their efforts to respond to the surge in demand, including transferring patients between levels of care as necessary. In case demand exceeds planned capacity in high-impact intervention areas like Acute Respiratory Infection (ARI) hubs, there is a plan to step up capacity. This could involve setting up additional ARI clinics, increasing testing and treatment capabilities.
	BLMK Response
KLOE-5.2: Early warning • Describe the system approach to monitoring demand and early warning systems in place.	SHREWD is used within the SCC and across BLMK partners. SHREWD Resilience shows the operational situation of local urgent care systems within a defined locality. Intuitive dashboards and RAG colour coding of each indicator provide a simple view of system pressures, allowing users to easily identify where pressure is coming from, the reason why it is happening, and act to address it. Where data in SHREWD is automated, (e.g. ambulance data) it is typically refreshed every 5-15 minutes, depending upon the rate of refresh individual trusts can support from their own systems. Where SHREWD is processing manual data, this is processed according to the custom and practice of individual trusts within the ICS. Site reports, for example, are typically shared 3-5 times per day.

KLOE 6: Workforce

	BLMK Response

KLOE-6.1: How will you ensure adequate staffing levels are in place to meet anticipated demand? • How have you modelled your workforce requirements for permanent clinical and non-clinical staff to deliver a resilient winter – ensure that you have considered all parts of the system. • Do you have the required level of staffing in place to deliver the planned capacity outlined in the 2023/24 operating plan for the system? • If there is a deficit in workforce what are your plans to meet this – how confident is the system in meeting this deficit? • How much temporary workforce is required to support across winter? • Have you onboarded current staff within all partner organisations to staff banks for deployment during periods of escalation? • What plans to you have to maximise the community workforce to ensure rehabilitation and reablement are delivered to all people requiring Intermediate Care services?	The BLMK system partners have modelled the workforce requirement for staff to be able to deliver as part of the integrated workforce planning undertaken with local and regional colleagues. As a system we are ahead of the trajectory for the 50K nurse recruitment ensuring the required level of staffing can be supported. This is supported through our Head of Safer Staffing who works with our Partner organisations to ensure actions can be taken to support demand and delivery. Between June 2022 and May 2023, there were 751 Nursing starters across BLMK. The system has undertaken a collaborative recruitment campaign to fill the vacancies within the HCSW workforce, including considerations for workforce required to deliver services throughout Winter. System partners have engaged in the collaborative campaign including Acute Trusts, Social Care and Primary Care. Early evaluations are showing significant increase in applications and shortlisting within our acute providers. Further attraction campaign for non-registered staff in the community with council and AHP partners planned for end of September which will support winter supply. To support retention of the workforce across Winter the ICS have implemented Legacy roles and have eight legacy roles in the system, exceeding numbers across the EoE region. Early evaluation is positive, our Legacy Lead is working with a regional HEI to support evaluation findings. Initial results from the BLMK Legacy Mentor interventions to date are very positive (n = 61) With HEI to report findings 89% had greater confidence in their role afterwards. • 84% felt more valued by their team. • 80% reported increased job satisfaction. • 94.7% “agree and strongly agreed” they were more likely to continue working in the NHS. We are working partners to implement a legacy nurse and legacy registered Care Home manager within social care, this is an area of fragility due to high attrition which we aim to correct and support pressures over winter. We are also working with partners to support a business case for Legacy social worker. First Legacy Paramedic (nationally) in post EEAST within Bedfordshire. MKUH are exemplar with NHS Flex and have developed a Flexi Pool: Work any time flexi pool initiative being created to allow employees to work hours that sit outside usual shift start times and lengths

	BHFT and MKUH have the 'pool' which provides flexible hours to staff Minimum of 6 and 4hrs shifts worked (respectively) The Nursing & HCA pool gives staff the opportunity to secure a permanent role to fit in with school drop off post but with the ability to choose their hours and shifts and self-roster. We have significant internationally educated nurses recruited this year, with many arriving and OSCE support to enable registration for the winter. Implementation of pastoral app (InterN app) which will support development, pastoral care and onboarding. System wide IR Career Coach supporting development of IEN's to progress and enable them to upskill into senior roles. 28 RN's promoted to B6 & B7 roles ready for winter. The ICB has implemented a bank contract to enable staff to work across the system and provide support to winter pressures where required. Our Primary Care colleagues have a Flexible Staff Pool in place for all Practices to utilise, currently onboarding additional Advanced Nurse Practitioners and Practice Nurses In depth work with PCNs to consider Winter pressures when recruiting to ARRS workforce plans has been undertaken. Maximising utilisation of ARRS funding across all PCNs, considering innovative employment models and recruitment at scale to overcome challenges of supervisory capacity and estates constraints support our winter pressures. Primary Care CPD programme is prioritising training to support with Winter pressures e.g., Imms & Vaccs, Spirometry & COPD. We are also bolstering Care Navigation capacity and increasing number of Personalised Care Roles to maximise community assets e.g., Citizens Advice Bureau hosting Social Prescribing Link Workers
KLOE-6.2: How will the system work together to support one another from a workforce perspective? Are the correct systems and processes in place to support	The system has an established HRD Network and System People Board that enables issues to be escalated and considered from a collaborative perspective. BLMK ICS has in place a Reservist workforce that can be drawn upon to support the winter pressures. We are mobilising this resource through meetings to discuss support to Primary Care during winter and

the deployment of staff from one provider to another where necessary?	these discussions are ongoing. Flexible Staff Pool platform in place to enable flexible working across practices and Urgent Primary Care providers. We have an existing MOU in place from Covid for the transfer of staff between our organisations. We will be refreshing this with our partner organisations. The ICB flow team works within our provider organisations, directly supporting them in flow and connections to social care colleagues and service provision. We have a well-attended Recruitment and Retention operational group across the system which can support any operational barriers. The group are reviewing reducing time to hire in recruitment processes to increase efficiency of new starters.
KLOE-6.3: How will staff wellbeing be prioritised across winter? • What initiatives are in placed to support staff wellbeing across the winter? • When is planned and unplanned absenteeism expected to be highest and are arrangements in place to ensure this is aligned with demand and capacity? What plans are in place to support a successful vaccination programme for influenza and Covid-19 if recommended for staff and volunteers?	BLMK ICS has a robust offering of initiatives available to staff. The Shiny Mind app, an evidence-based, proven mental health Midwifery and Healthcare Support and wellbeing app, co-created with the NHS is supporting the wellbeing and resilience of our hardworking staff. Initially available to Primary Care staff across BLMK, this product is now available to all staff across the system including social care workers 111 callers. There is a bespoke version available to Nursing, Midwifery and HCSW staff specifically catered to their need and work demands. The Shine Programme, an empowering digital approach between NHS Arden & GEM CSU's digital transformation team, NHS Bedfordshire, Luton and Milton Keynes ICB, and ShinyMind, has been shortlisted in the 'Improving Mental Health through Digital' category for the upcoming HSJ Digital Awards 2023. Health & Wellbeing Champion Network established within Primary Care. Champions undergoing specialist training programme and processes in place for cascade support. Ongoing 121 targeted support with Health & Wellbeing & resilience for all practices and PCNs according to need. CPD programme for Primary Care commencing with additional Imms & Vaccs training. In addition, we have implemented the InterN App through innovation funding secured with collaboration with H&WE ICS to implement a digital app, supporting IR Nurse pastoral and career development in BLMK. The app has been launched in April 2023 and will support our workforce through winter pressures.

	We have also implemented the Peppy App and service which is a Menopause support app, doing 'more than an app' is available to staff within the ICB, providing menopause support and sessions to navigate through a significant transition in life. The Keeping Well Hub is offered to all staff across BLMK with an array of options for wellbeing support and is available to all key workers within the system. The service is currently transitioning to the new Regional Hub model delivered by an experiences provider and will be in place to support staff over the winter period. The service is offered in addition to the OH and Wellbeing offers within each of our Partner organisations There are also Peer listeners / Peer Buddy models available and BHFT have them available for all staff with two Safe Spaces open - one on each site and manned by volunteers and Peer Support is available at MKUH BHFT Structured wellbeing conversations are now embedded into the Trust's appraisal system and cover mental and physical health, equity and fairness, alignment to values, relationships and connections, time to do a great job, job satisfaction and engagement
KLOE-6.4: How are you maximising the role of VCSE partners? • What assumptions have been made about the role of VCSE partners in supporting the workforce this winter? • What steps have you taken to maximise the role of VCSE partners this winter? • How will the relationship with VCSE partners be managed at a system-level to ensure the greatest level of integration and joint working? What steps has the system taken to maximise the role of NHS and Care Volunteer Responders?	The current VCSE contracts across BLMK with AgeUK, Age Concern, British Red Cross and Noah (homeless charity) will continue to support hospital discharge throughout the winter. VCSE organisations across BLMK have been invited to at place planning meetings to present specific support they can offer over winter. An additional winter planning workshop is being arranged via the LA for VCSEs across Bedfordshire. In MK the development of the Integrated Discharge Hub includes a VCSE role.

	Invites to meetings/workshops have included the Local Project Manager for the NHS Volunteer Responders. Additional schemes often come with funding requirements so although winter schemes are available it may not be possible to take these forward.