


Service Change Policy

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Implementation Plan

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Equality, Diversity and Privacy:	Appendix 1 - Equality Impact Assessment Appendix 2 - Data Protection Impact Assessment
Associated Documents:	The following documents must be read in conjunction with this document: <ul style="list-style-type: none"> ▪ N/A – procedural detail is contained within Section 6.0
References:	The following articles were accessed and used to inform the development of this document: <ul style="list-style-type: none"> ▪ BLMK ICB Programme & Project Management Policy (Previous Version) ▪ BLMK ICB Project Management Framework (Previous Version) ▪ The Health Care Services (Provider Selection Regime) Regulations 2023 ▪ Working in partnership with people and communities: statutory guidance

Table of Contents

1.0	Introduction	6
2.0	Scope	6
3.0	Definitions	7
4.0	Policy Statement	9
5.0	Roles and Responsibilities	9
6.0	Processes and Procedures	11
6.1	Prerequisites before undertaking service change.	11
6.2	Verto 365.....	12
6.4	Timescales for each Stage (to support planning)	14
6.5	The Service Change Methodology Explained	16
	Start-Up	16
	Requirements & Design.....	22
	Initiation	30
	Implementation.....	37
	Mobilisation & Go-Live.....	41
	Testing, Monitoring & Closure	42
	Appendix 1 - Equality Impact Assessment Initial Screening.....	45
	Appendix 2 - Data Protection Impact Assessment Initial Screening.....	47

1.0 Introduction

- 1.1 NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB) aims to ensure robust governance through its formal written procedural documents, such as this document, which communicate standard organisational ways of working. These documents help clarify operational requirements and consistency within day-to-day practice. They can improve the quality of work, increase the successful achievement of objectives and support patient safety, quality and experience. The ICB aims to ensure its procedural documents are user friendly, up-to-date and easily accessible.
- 1.2 The ICB must design and implement procedural documents that meet the diverse needs of our service and workforce, ensuring that none is placed at a disadvantage over others, in accordance with the Equality Act 2010. The Equality Impact Assessment initial screening, which was used to determine the potential impact this policy might have with respect to the individual protected characteristics is incorporated at Appendix 1.
- 1.3 A Data Protection Impact Assessment is a process which helps assess privacy risks to individuals in the collection, use and disclosure of personal information. The Data Protection Impact Assessment initial screening, which was used to determine the potential impact this policy might have with respect to an individual's privacy is incorporated at Appendix 2.
- 1.4 The Service Change Policy provides staff with:
- A methodology for service change that adheres to the BLMK ICB Constitution and UK parliament primary legislation including - The Health & Care Act 2022, Equality Act 2010, Data Protection Act 2018 and Public Sector Procurement law (Procurement Act 2023 coming in October 2024).
 - A 'one-stop-shop' document for both clinical and non-clinical services change.
 - A series of tools, techniques and guidance based on best practice and real-world experiences of undertaking service change.
 - Help with choosing the right project management approach and associated tools, techniques, and guidance to best ensure the service change is managed effectively and efficiently.
 - When this policy refers to service change, this includes commissioning new services, making changes to existing services or decommissioning a service.

2.0 Scope

- 2.1 Any changes to clinical and non-clinical services and goods commissioned by BLMK ICB are within scope of this policy.

This policy applies to:

- Any member of ICB staff wanting to undertake a service change.
- Any partner organisation involved in ICB initiated service change activities as part of a project team or wider stakeholder group.

This policy does not apply to:

- Any partner organisation wanting to initiative a service change for a service they provide (as they will follow their own policy on service change) following ICB approval (if required).
- Any member of ICB staff or partner organisation wanting to make changes to Workforce or Estates.

Important Notes:

- This policy will detail a single methodology that covers all types of service change including commissioning new services, making changes to existing services or decommissioning a service.
- The single methodology is explained in section 6.0 of this policy. Before your service change journey commences, there are a number of important prerequisites to understand and adhere to. These are listed at the beginning of section 6.0.

3.0 Definitions

3.1 This section provides staff members with an explanation of terms used within this policy.

3.2 The following terms have been used within this policy:

Term	Definition
Portfolio	Strategic Grouping, Focus on maximising return on investment, Balanced mix of projects and programmes, Ongoing, Higher risk
Programme	Focus is on outcomes, Higher Complexity than projects, Longer Timescale, Higher Budget, Scope is less defined, Higher Risk
Project	Focus is on outputs, Less Complex, Defined start and end dates, Agreed total budget, Defined Scope, Less Risk
Senior Responsible Owner (SRO)	The individual responsible for ensuring that a programme or project meets its objectives and delivers the projected benefits
Programme or Project Manager	The individual responsible for planning and coordinating projects, from inception to delivery - managing resources, budget, and people to achieve a desired outcome
Waterfall Project Management	The waterfall project management approach entails a clearly defined sequence of execution with project phases that do not advance until a phase receives final approval

Model for Improvement	The 'Model for Improvement' is the framework for driving continuous improvement. It is essentially a method for structuring an improvement project.
Institute for Healthcare Improvement (IHI)	The Institute for Healthcare Improvement (IHI) is a leading, globally recognized not-for-profit health care improvement organisation that has been applying evidence-based quality improvement methods to meet current and future health care challenges for more than 30 years.
Commissioning	The process of planning, agreeing and monitoring services
Decommissioning	The planned process of removing, reducing or replacing health-care services
Service Change	A term used to cover all types of change to services in this policy, whether it be commissioning, decommissioning or changing.
Co-Production	Co-production is a way of working that involves people who use health and care services, carers and communities in equal partnership
Co-Design	Designing with people and incorporating their ideas into the final approach
Co-Evaluation	Evaluating a service with residents
Informing	Where appropriate, making changes to services without the direct engagement of residents and then informing residents of the outcome
Provider Selection Regime (PSR)	The Provider Selection Regime (PSR) provides flexibility so that each relevant authority can take local decisions to arrange health care services in a way that best suit the needs of their patients and service users at that specific time
Verto 365	Verto 365 is a project management and collaboration system adopted by BLMK ICB
Executive Mandate	The Executive Mandate is the first agreement required to initiate a project. The Mandate is a pre-project requirement; it encapsulates the ideas and basic information that is available at this point.
Need for Change	An evidence base for justifying making changes to services based on academic studies and facts
Clinical Advisory Group (CAG)	The group within BLMK ICS that is responsible for reviewing QIAs, EQIAs and HEAT from a clinical/ethical perspective
Driver Diagram	A driver diagram organises information on proposed activities so the relationships between the aim of the improvement project and the changes to be tested and implemented are made clear
Business Case	Provides justification for undertaking a project or programme. It evaluates the benefit, cost and risk of alternative options and provides a rationale for the preferred solution.
Quality Impact Assessment (QIA)	The purpose of a QIA is to determine whether a change being proposed in a project will have a positive, neutral, or negative impact on patient safety, clinical effectiveness, and patient experience and involvement.
Equity Impact Assessment (EQIA) and Health Equity Assessment Tool (HEAT)	The purpose of an EQIA and HEAT is to ensure that services, policies, and practices do not directly, indirectly, intentionally,

	or unintentionally discriminate against the users of services or on staff.
Data Protection Impact Assessment (DPIA) Tool	A DPIA is a process which helps to identify privacy risks to individuals (data subjects) in the processing of their information/data e.g. viewing, transferring, obtaining, using, sharing, collating, storing etc
Environmental & Social Impact Assessment (EaSIA) Tool	The EaSIA tool helps consider the wide range of possible impacts that a proposed project could have on the building blocks of health. It supports identifying the impact on statutory and related duties from the Health and Care Act pertaining to environment and social factors.
Executive Group	The meeting of the chiefs with decision-making powers based on the ICBs Standing Financial Instructions (SFIs)
Operational Group	The meeting of the deputy chiefs with devolved authority from the Executive Group
Financial Improvement Group (FIG)	Responsible for overseeing Efficiencies and Productivity programmes and pipeline
Investment Oversight Group (IVOG)	Responsible for grip and control overspend over £5k
Finance & Investment Committee (FIC)	A constituted committee of the Board responsible for the financial business of the ICB
ICB Board	Overall responsibility for healthcare across BLMK ICS
Statistical Process Control (SPC) Charts	SPC charts (Statistical Process Control Charts) are used to measure changes in data over time
'Double-Lock'	Individual organisations and system holding themselves to account for good financial management and achieving financial balance through the introduction of greater grip and control over expenditure
'Triple-Lock'	Similar to 'Double-Lock', however also includes even greater scrutiny, grip and control over expenditure with greater involvement from NHS England.
Quintuple Aim	The Institute for Healthcare Improvement (IHI) Quintuple Aim framework serves as the foundation for optimising health for individuals and populations by simultaneously (1) Improving Resident Experience, (2) Improving Population Health, (3) Improving Value for Money, (4) Advancing Health Equity and (5) Ease of System Implementation (minimising clinician burnout)

4.0 Policy Statement

- 4.1 To ensure all service changes managed and delivered by the ICB adhere to the BLMK ICB Constitution and UK parliament primary legislation.

To ensure all service changes are managed consistently, efficiency and effectively.

5.0 Roles and Responsibilities

5.1 The following have specific responsibilities in relation to this policy. Full details of each of the following group's responsibilities is detailed within Section 6.0:

5.2 The ICB Board

Approval of Business Cases that are either £500k or more (life of contract value) or Business Cases that significantly impact on how or where residents access services.

5.3 Finance & Investment Committee (FIC) & Quality & Performance Committee (QPC)

Approval of Business Cases that are either £500k or more (life of contract value) or Business Cases that significantly impact on how or where residents access services.

5.4 Executive Group & Operational Group

Appraisal and approval of all Business Cases regardless of cost or impact on how or where residents access services. Operational Group provides the appraisal, and Executive Group provides the approval. You cannot obtain Business Case approval at Executive Group without already obtaining appraisal at Operational Group.

5.5 Clinical Advisory Group (CAG)

Provides recommendations to the Operational Group, Executive Group, Finance & Investment Committee, Quality & Performance Committee and ICB Board based on the information provided in QIAs, EQIAs and HEAT on the clinical and ethical perspective on proposed changes.

5.6 Financial Improvement Group (FIG)

Provides oversight, grip and control of the Efficiencies programme and associated pipeline.

5.7 Investment Oversight Group (IVOG)

Provides oversight, grip and control over investments over £5k. Business Cases proposing 'invest to save' or proposing to spend budgeted spend, which are over 5K, will need to go through IVOG as well as Ops Group and Exec

5.8 Overview and Scrutiny Committees (OSCs) and Health & Wellbeing Boards (HWBs)

The Overview and Scrutiny Committees do not have decision-making powers, but are able to make recommendations to the Executive, Council and other local partners about decisions, services and issues of local concern.

Health and wellbeing boards (HWBs) are a key mechanism for driving joined up working at a local level. More information on OSCs and HWBs is contained later in the policy in the 'Visiting OSCs & H&WBBs' section of 'Initiation' stage.

5.9 NHS England

The NHS England Project Appraisal Unit is a small specialist central team within NHS England Strategic Finance comprising of experienced capital investment and estates professionals who will be available to provide support to officers of NHS England at local Director of Commissioning Operations (DCO) offices, Sustainability and Transformation Partnerships, Regional Team, Commissioning Support Units, Commissioning Support Unit Transition Team (CSUTT), National Team levels, and to ICBs.

6.0 Processes and Procedures

6.1 Prerequisites before undertaking service change.

The single methodology for service change is explained in this section of the policy. Before the methodology is explored, there are a number of important prerequisites before work can commence. These are listed below:

Checklist of Key Factors to consider before making any changes to services:

Resident Engagement	How are you going to engage with residents? The ICB has a duty under the Health & Care Act 2020 to engage with residents on changes made to healthcare services. The options for engaging with residents can be distilled into Co-Production, Co-Design, Co-Evaluation and Informing. Deciding which path to take is explained later in this policy.
Type of Service Change	What type of change is being recommended? Depending on the outcome of your engagement with residents and internal ICB approval, your recommended option to change a service can be distilled into commissioning a new service, acquiring a good, adapting an existing service or decommissioning a service.
Project Management Approach	How are you going to project manage your service change? Depending on a number of factors including the type of change being proposed, the skills in the team, the maturity of the change environment, and the outcomes being sought – there are a number of project management approaches that can be used. These include Waterfall, Quality Improvement (QI) and Agile. All three approaches are explained later in the policy.
Procurement and Contract Options	How are you going to acquire a new service or good, or acquire a new provider of a service or good? How are you going to contractualise your change? Procurement options including the Provider Selection Regime (PSR) are explained in more detail later in the policy, but are also further explained in the BLMK ICB Procurement Policy. Forming a contract, to ensure both commissioner and provider know what is expected, is also covered later in the policy
The Political Environment	What political events are currently active or on the horizon, and how does that influence whether to make a service change? Be aware that if you are proposing to make material changes to services that impact on how or where residents access services, then you will need to seek Communications & Engagement Team advice on political sensitivity and how this will impact on timescales. This area is covered later in the policy
Budget	Have you identified a source of funding for your service change? Your Finance Lead can advise on options. Options can include current budget underspends, efficiencies, identified budget or external funding. If you are

	considering securing external funds via a bid or grant there is a separate External Bid & Grant Process you will need to know about (available on the PMO pages of the Intranet). Remember, regardless of your source of investment funding, if it's over £5k, you will need to attend the Investment Oversight Group (IVOG). Budget is covered later in the policy
Resources	Do you have the resources to carry out the service change? Make sure you are aware of the resources you will need to carry out the service change. Either you have the resources lined up or you will need to include any additional resources required in the Business Case. Resources are covered later in the policy.
NHS England	Does NHS England need to know about your service change? Make sure you are aware of when a service change triggers NHS England involvement. Covered later in the policy
Evidence-Based Need for Change and Strategic Alignment	Do you have an evidence-based need for change? Is your proposed change a Priority? Do your root cause analysis, understand the problem you are going to fix, use Fishbone Diagrams and Driver Diagrams to better understand causes and potential solutions, and ensure any potential solutions are evidence-based by NICE TA guidance, academic studies or real-world best practice examples. Do you understand your population? Have you undertaken the Population Health analysis that shows current and future need. Make sure your potential solutions align to BLMK ICB strategies and Priorities. All explored later in the policy.
The degree of Financial Governance in operation in the ICB	At the time of writing this policy the ICB has enforced 'Double-Lock' on itself which includes the adoption of an Investment Oversight Group (IVOG). It is possible that 'Double-Lock' could be lifted, or 'Triple-Lock' could have been enforced depending on the financial position of the ICB. It is important to understand the level of scrutiny on finances at the time of thinking about making changes to services, especially if you need investment.

6.2 Verto 365

BLMK ICB has access to a Project Management and Collaboration System called Verto 365.

Verto 365 is a one-stop-shop for managing portfolios, programmes, and projects (both waterfall and improvement).

The ICB PMO team administer Verto 365 and the organisation has access to 100 staff pro licenses and 750 staff workspace licenses.

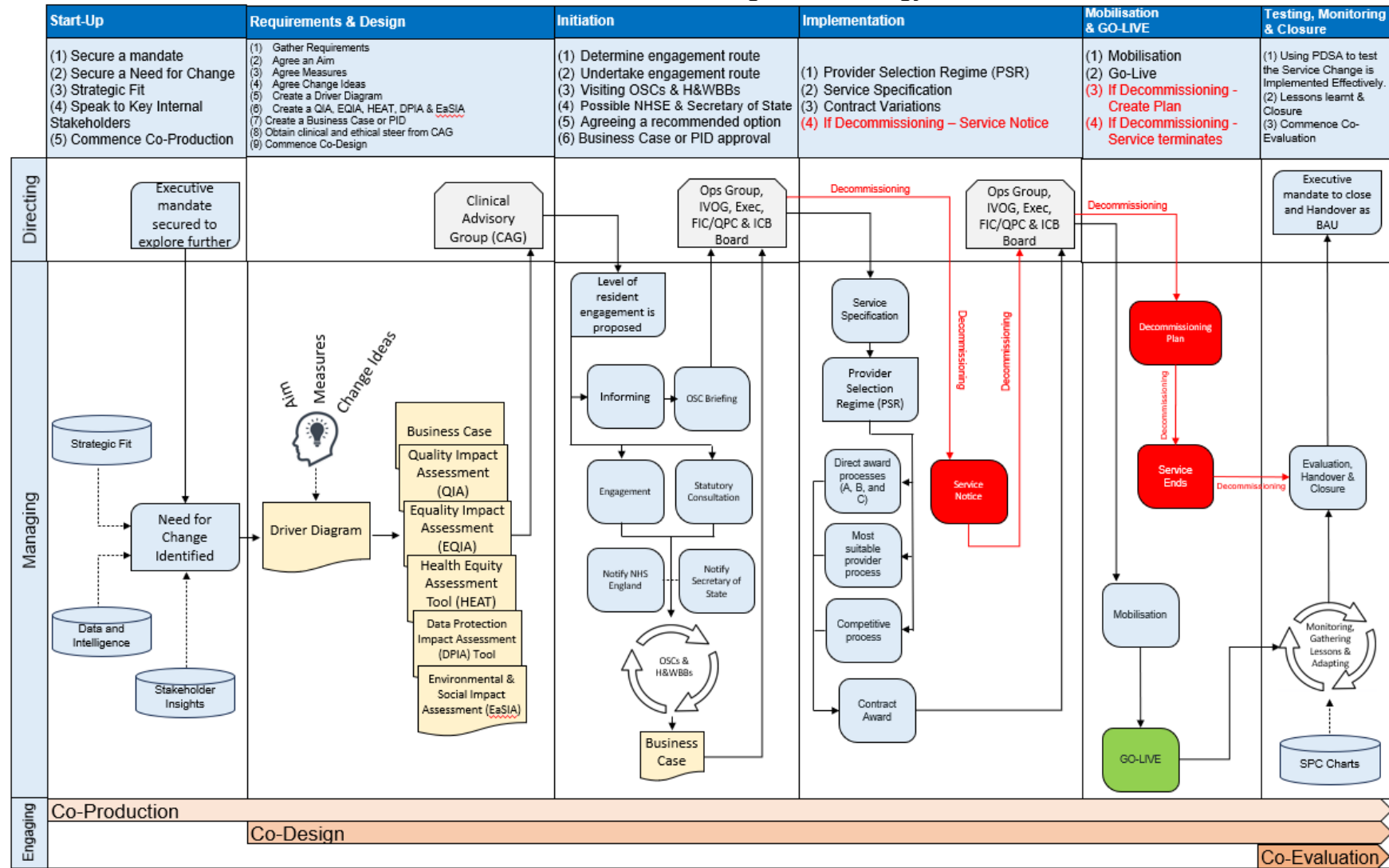
Many of the tools mentioned through this Policy are available on Verto 365.

This Policy will not cover how to use Verto 365, as there is separate guidance and training packages for using Verto 365 – all available through the PMO Team.

All BLMK ICB-Led (or heavily involved in) Priority Programmes should be managed via Verto 365. This is to ensure programmes and projects are managed consistently and that all information is in one place.

If you are about to embark on a new Commissioning, Decommissioning or Service project please speak to the PMO about starting the project management journey on Verto 365

6.3 The Service Change Methodology



6.4 Timescales for each Stage (to support planning)

To support people in planning for service change, this policy provides some guidance on timescales for undertaking each of the Stages in the above Service Change Methodology. However, these timescales are described as a range, as every service change is different, and a service change can vary from a small pilot such as establishing a Diabetes Self-Management service in a PCN, to a large multi-year re-procurement of Community Health Services in BLMK. The below table provides some guidance on timescales:

Stage	Timescale Range	Comments
Start-Up	1 Week → 1 Month	<p>Start-up timeframes can vary depending on the existence of a source of need for change and the scale of the issues/cause triggering an investigation.</p> <p>For example, if it's the ICB responding to a NICE TA, then more of the evidence base already exists and the focus would be more on modelling the impact for BLMK – which would be a shorter timeframe.</p> <p>Or for example, if a Health Needs Assessment needs to be created and/or bespoke Population Health analysis needs to be created then this can take more time.</p> <p>If you are beginning to allocate time for Start-Up, allow for up to 1 month – for a more accurate estimate of time, please speak to the teams responsible for creating the source of the data.</p>
Requirements & Design	1 Week → 1 Month	<p>If you are allocating time for Requirements & Design, please allow for up to 1 month depending on a number of factors.</p> <p>The creation of the Driver Diagram, outline Business Case and populated Impact Assessments could be done in 2 weeks or less, but you may need to allow more time for socialising these deliverables and potentially co-creating them with stakeholders and even residents.</p>
Initiation	2 Weeks → 6 Months	<p>If you are allocating time for Initiation, please allow for up to 6 months depending on a number of factors.</p> <p>The timeframes for this stage will vary quite significantly depending on the 'significance' of the change being proposed.</p> <p>NHS statutory consultations with residents typically take a minimum of 12 weeks. This timeframe is designed to ensure that the public has adequate opportunity to engage, provide feedback, and participate in discussions about proposed changes to local health services.</p> <p>In some cases, particularly for more complex issues or significant service changes, consultations may extend beyond 12 weeks to allow for deeper engagement and additional feedback. The specific duration can vary based on factors such as the nature of the proposed changes, the level of community interest, and the need for follow-up discussions or additional information sessions. Overall, the goal is to ensure meaningful participation and to incorporate resident input into decision-making.</p>

Implementation	1 Month → 8 Months	<p>The timeline for following the provider selection regime for NHS services can vary significantly depending on several factors, such as the complexity of the services involved, the regulatory requirements, and the level of stakeholder engagement. Typically, the process can take anywhere from a few months to over a year.</p> <p>Key stages include:</p> <p>Preliminary assessment and planning (1-3 months): Identifying needs and options for service delivery.</p> <p>Market engagement (1-2 months): Consulting with potential providers and stakeholders.</p> <p>Formal procurement process (3-6 months): This includes developing and issuing tender documents, evaluating bids, and selecting a provider.</p> <p>Transition period (1-6 months): Implementing the transition to the new provider while ensuring continuity of care.</p> <p>Overall, careful planning and stakeholder involvement can help streamline the process and address any challenges that arise.</p>
Mobilisation & Go-Live	1 Month → 6 Months	<p>Mobilizing a new NHS service can vary significantly in duration depending on various factors, such as the complexity of the service, funding availability, staffing needs, and regulatory requirements. Typically, it might take anywhere from several months to a few years.</p> <p>Key steps involved include planning and consultation, securing resources, recruiting and training staff, and ensuring compliance with healthcare standards.</p>
Testing, Monitoring & Closure	1 Month → 12 Months	<p>If you are allocating time for Testing, Monitoring & Closure please allow for up to 12 months depending on a number of factors.</p> <p>Similar to other stages the time needed for this stage will vary depending on factors such as the number of PDSA cycles you want to conduct, the length of time you want to allow for testing and again its largely dictated by the size and scale of the change. As a minimum we would recommend keep a service change project open for a minimum of 6 months for testing and evaluation, before it becomes BAU.</p>

6.5 The Service Change Methodology Explained

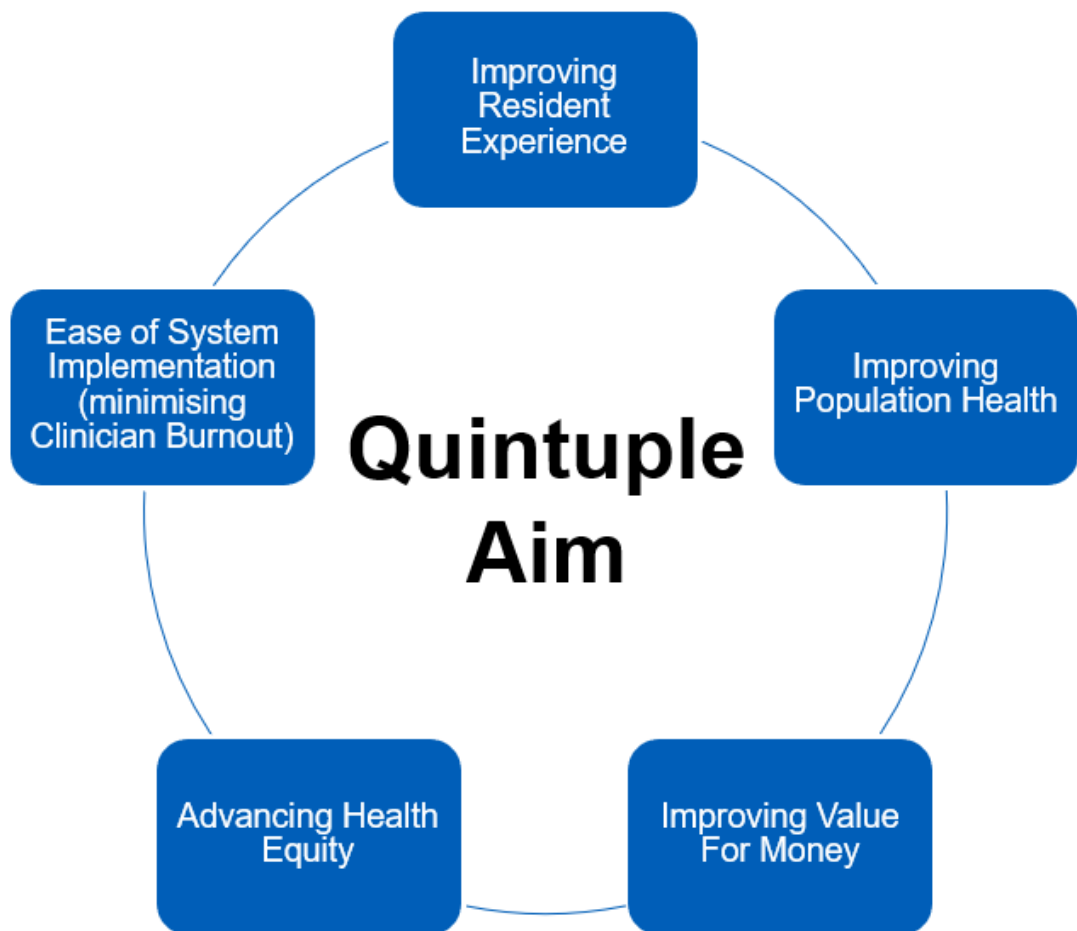
The Service Change Methodology Explained	
Start-Up	
Expectation	Description of Expectation
(1) Secure a Mandate	<p>Before any work can be started on any service change a mandate needs to be secured.</p> <p>The mandate provides the authority for an individual to begin any service change.</p> <p>A mandate can come from both internal and external sources. Internally it can come from the Executive Group, or externally it can come from organisations such as NHS England or NICE.</p> <p>Sometimes mandates are mandatory (for example new law or legislation), and sometimes mandates are optional (for example when external funding becomes available to bid for)</p> <p>Regardless of where the mandate has come from, every mandate needs to be authorised by a member of the Executive Group. This authorisation can be in the form of an email from the member of the Executive Group.</p> <p>Once a mandate is obtained and authorised, work can commence on securing a need for change, gathering requirements, gathering data, and engaging with key internal stakeholders.</p>
(2) Secure a Need for Change	<p>Any service change needs to be evidence based.</p> <p>This evidence base can come from existing academic studies or publications that have been undertaken by recognised organisations such as NICE or Nuffield, or existing academic studies or publications commissioned by NHS England, such as Right Care or GIRFT. It can also come from Local Authority and Public Health publications such as the JSNA or Fingertips.</p> <p>It can come from existing studies commissioned internally, such as work created by AGEM Business Intelligence, Population Health Management or from the Health Services Strategy.</p> <p>In many cases any evidence base that already exists will likely need to be either (1) re-examined from a BLMK perspective, (2) re-examined to ensure its still relevant and up-to-date or (3) will require a 'deep dive' into segments of the BLMK population.</p> <p>If you need to refresh, localise or 'deep dive' into an existing evidence base, or create a new evidence base, then it is important to know what sources of data and intelligence you can access.</p> <p>The following are recognised sources of data and intelligence to generate a local BLMK evidence base:</p> <ul style="list-style-type: none"> • Population Health Management Team • AGEM Business Intelligence • The Model Health System

	<p>For more information on the above sources of data and intelligence, you can speak to the ICB Performance Team, our Business Intelligence leads or the Population Health Intelligence Unit (PHIU)</p> <p>If you have created a source of data or intelligence yourself as an evidence base for your service change, it is recommended you check its accuracy with Subject Matter Experts and Clinical Leads, to ensure you are designing solutions on an accurate evidence base foundation.</p>
(3) Strategic Fit	<p>Any changes being proposed via commissioning, service change or decommissioning need to align to our BLMK ICS Strategies.</p> <p>Our Strategies guide what we do as an organisation and help us all work towards common goals.</p> <p>Listed below are several key BLMK ICS Strategies (but not all of them) you should ensure your proposed service change aligns with:</p> <ul style="list-style-type: none"> • BLMK NHS Long Term Plan • BLMK Health & Care Strategy • BLMK Joint Forward Plan • BLMK Operational Plan • BLMK Population Health Management Strategy • BLMK Working with People and Communities Strategy • BLMK Digital Strategy • BLMK Data Strategy • BLMK Mental Health, Learning Disabilities and Autism Strategy • BLMK Health Services Strategy • BLMK ICS Green Plan <p>You can access the Strategies above from the ICS website - https://blmkhealthandcarepartnership.org/our-strategies/</p> <p>The above BLMK ICS Strategies provide high-level guidance and steer, however the ICB has narrowed down, using prioritisation, a more granular list of priority programmes as per below:</p> <ul style="list-style-type: none"> • Integrated Neighbourhood Working • ICB Internal Efficiency Programme • UEC • Mental Health UEC • Primary Care Access <ul style="list-style-type: none"> ○ Integrated Urgent Care ○ NHS App • Cancer Transformation • System Response to The Denny Review • Non-Acute Diagnostics <ul style="list-style-type: none"> ○ Community Paediatrics & CAMHS ○ ASD & ADHD • Complex Care <ul style="list-style-type: none"> ○ CHC ○ S117 ○ Children's Complex Care

- 0-19 Transformation & Procurement
- Community Services Transformation & Procurement
- Mental Health Services Transformation & Procurement
- MSK
- Contractual Transformation

Like the BLMK ICS Strategies, please check alignment to the above ICB Priority Programmes before proceeding any further.

The Institute for Healthcare Improvement (IHI) Quintuple Aim framework serves as the foundation for optimising health for individuals and populations by simultaneously (1) Improving Resident Experience, (2) Improving Population Health, (3) Improving Value for Money, (4) Advancing Health Equity and (5) Ease of System Implementation (minimising clinician burnout).



All new considerations for change should look to the Quintuple Aim to ensure the change you are proposing meets the five aims.

Strategic Fit will be revisited later on in both the Design and Initiation stages; for example, you will be asked to provide some narrative in the Business Case on Strategic Fit.

(4) Speak to Key Internal Stakeholders

It is important at this early stage that you begin to 'put out feelers' internally that you are potentially going to embark on a service change.

This is important for several reasons; (1) to make key internal stakeholders aware of your intentions, (2) if you need certain key stakeholders to support your service change then it is important you make them aware of what is needed from them and when, and (3) to ensure you are aware of what is expected of you.

Below is a list of key internal stakeholders and suggested topics you may want to consider before you embark on your service change. Depending on the changes you are proposing, you may not need to reach out to all the below key stakeholders, but it is recommended that if you are in any doubt, to reach out to be on the safe side.

Finance

- Funding and investment.
- Efficiencies and productivity.
- Financial Modelling

Research & Innovation

- Accessible innovation networks for people to tap into
- Funding sources available through technology funds
- Innovative solutions already out there that we can learn from and adopt.

Subject Matter Experts in the ICB Core

Depending on your service change you will likely need to turn to Subject Matter Experts in the organisation. The following is a list of Subject Matter Expert teams within the ICB. If you need to know who to contact in these teams, please refer to the latest ICB Organogram available via the Intranet -

<https://intranet.bedfordshirelutonandmiltonkeynes.icb.nhs.uk/blmk-icb-structure>

- Childrens, Young People and Maternity Services
- Mental Health, Learning Disabilities and Autism Services
- Elective Services
- UEC Services
- Cancer Services
- Better Care Fund
- Workforce
- Estates
- Medicines Optimisation
- Primary Care
- Prevention
- Continuing Health Care

Quality

- Quality considerations and the Quality Impact Assessment (QIA)
- Clinical Advisory Group (CAG)

Equality, Inclusion & Diversity (via AGEM)

- Equality Impact Assessment (EQIA)
- Health Equity Assessment Tool (HEAT)

Quality Improvement Team

- The Model for Improvement – when to use the Model for improvement.
- Driver Diagrams
- Statistical Process Charts (SPC)
- Plan, Do, Study, Act (PDSA)
- Outcomes, Process & Balance Measures
- Institute of Healthcare Improvement (IHI) and the Local Area Networks (LANs)

Contracting (and procurement via AGEM)

- Current contracts – type of contract, size of contract, duration of contract, expiration dates, history, service specifications, particulars etc
- Contracting and Procurement law
- Contracting and Procurement options going forward
- Whether you need contracting or procurement resource for your project

Communications & Engagement

- Political considerations, information on political landscape, MPs, Councillors etc
- Co-Production, Co-Design, Co-Evaluation
- Resident Informing, Engagement and Consultation
- Overview and Scrutiny Committees (OSCs)
- Secretary of State considerations
- Stakeholder Mapping
- Communications & Engagement Plans

VCSE

- Service provider data and insights
- Resident insights, especially in relation to seldom heard groups.
- Person centred and psychosocial interventions.
- VCSE Strategy Group and Partnership Team
- Local engagement forums, networks and expert leaders
- Service improvement and pathway development
- Innovation and new models of delivery
- Sources of external funds

Performance, Business Intelligence & Population Health Management

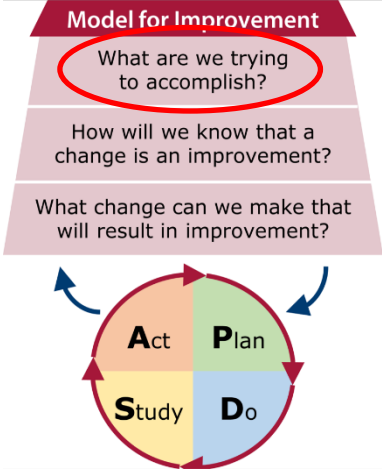
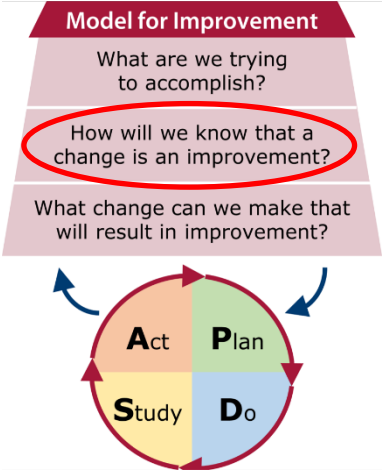
- Requests for Data and information
- Data discovery evaluation –current data, dashboard / reporting available.
- Population Health intelligence
- Analytics, benchmarking and visualisation
- Contract information/data schedule requirements
- Performance insight and reporting

	<p>Sustainability and Growth</p> <ul style="list-style-type: none"> • Environmental sustainability and Sustainable Healthcare considerations • Climate Change risks and impacts • NHS and BLMK net-zero carbon ambitions. • ICS Green Plan • Social and economic development • Anchor institutions and networks • Environment & Social Impact Assessment (EaSIA) and the EaSIA Tool <p>Digital</p> <ul style="list-style-type: none"> • ICS Chief Digital Information Officer (CDIO) involvement • Alignment to published ICS Digital and Data Strategies • Alignment to NHS England digital priorities and national programmes, What Good Looks Like Framework • Alignment to ICS partner digital strategies • Whether you need Digital resource for your project • Interdependencies with and alignment to existing digitally enabled programmes and associated considerations. <p>Safe Practice (Information Governance)</p> <ul style="list-style-type: none"> • Data security, data flows and safe practice • Information Governance and the Data Protection Impact Assessment (DPIA) • Whether you need any Information Governance resource for your project <p>System Transformation Team (STT)</p> <ul style="list-style-type: none"> • Interdependencies with existing transformation programmes • Whether you need STT support in your project <p>Place Teams</p> <ul style="list-style-type: none"> • Interdependencies with existing Place Priorities and key commissioners and providers at Place e.g. the Local Authority, Hospital etc. • Engagement with Place, including the Place team and the wider Place network e.g., Safeguarding and Quality leads. • Knowledge of Place, e.g. people, forums, relationships etc • Whether you need Place support in your project <p>Programme Management Office (PMO)</p> <ul style="list-style-type: none"> • Verto 365 • Portfolio, Programme & Project expertise • External Bids & Grants • Awareness of Portfolios, Programmes & Projects in the BLMK System
(5) Commence Co- Production	<p>If you have chosen to adopt Co-Production for your service change, it is at this stage you will want to begin engaging with residents, right at the beginning.</p> <p>For more information on how best to engage with residents early on, speak to the Communications & Engagement Team.</p>

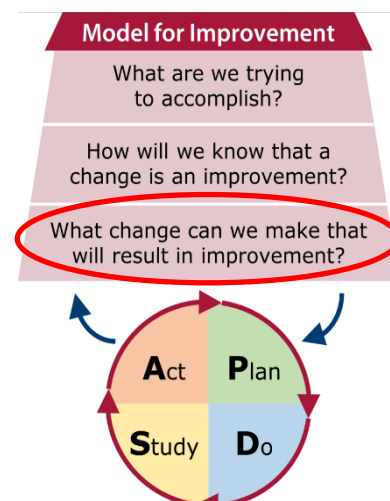
The Service Change Methodology Explained

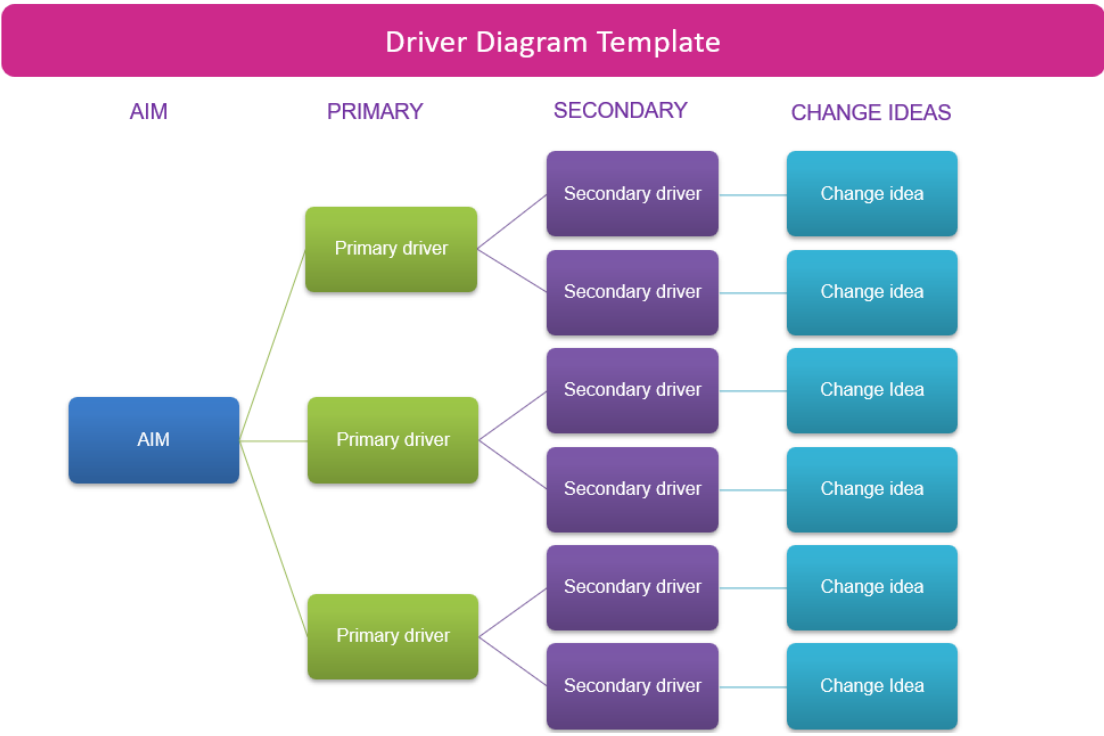
Requirements & Design

Expectation	Description of Expectation
(1) Gather Requirements	<p>Once you have secured a mandate, gathered a need-for-change evidence base, and put feelers out internally, you need to begin gathering requirements from key stakeholders.</p> <p>Depending on the type of service change , you will likely need to gather requirements from ICB colleagues, provider colleagues and residents (depending on the level of Co-Production or Co-Design)</p> <p>Requirements gathering is the process of identifying your service changes exact requirements from start to finish.</p> <p>Requirements gathering may seem self-explanatory, but it rarely receives the full attention it deserves. Like stretching before exercising or brushing your teeth before bed, it's a simple task that often gets overlooked.</p> <p>There are many technquies for gathering requirements, but one way that works well is User Stories – which is an Agile technique. If you would like to know more about User Stories, then please contact the PMO.</p> <p>A User Story is a requirement expressed from the perspective of an end-user goal – for example a service user or resident.</p> <p>A User Story is really just a well-expressed requirement. The User Story format has become the most popular way of expressing requirements in Agile.</p> <p>User Stories provide a powerful message. Choosing User Stories to define requirements demonstrates an intention to work collaboratively with the users to discover what they really need. The diagram below shows an example of gathering a User Story:</p> <div data-bbox="338 1272 1444 1966" style="border: 1px solid black; padding: 10px; margin-top: 10px;"> <h3 style="text-align: center;">How to write an agile user story</h3> <ol style="list-style-type: none"> 1 Define your end user Who will be using your product? As a parent, 2 Specify what they want What solution are you offering? I want to check on my sleeping baby without entering his room, 3 Describe the benefit What will your user gain from using your product? so that I know he is safe without disturbing him. 4 Add acceptance criteria What determines this story as 'done'? e.g. Alert to be sent to the registered smartphone if problem is detected. </div>

	<p>A User Story template or 'Card' is available from the PMO should you need one. It is also available on Verto 365.</p>						
<p>(2) Agree an Aim</p>	<p>Once you have begun gathering requirements, you need to identify and agree an Aim.</p> <p>As per the Model for Improvement diagram on the right, the aim helps us answer 'What are we trying to accomplish?'</p> <p>Identifying and agreeing an Aim with your key stakeholders (and residents if you are taking a Co-Production approach) is an important early deliverable in your service change.</p> <p>An Aim is a statement of purpose that describes the improvement goals in time-specific, quantitative measurable terms with the context of a specific population.</p> <p>When it comes to defining the Aim, one key aspect to consider is the residents perspective. Would residents understand your aim? Does your aim reflect what residents want from the service change?</p> <p>Once you have an Aim, start populating the Driver Diagram.</p> 						
<p>(3) Agree Measures</p>	<p>Once we have agreed an Aim, you will need to agree some Measures.</p> <p>As per the Model for Improvement diagram on the right, agreeing measures helps us answer the 'How will we know that a change is an improvement?' question.</p> <p>Identifying and agreeing Measures with your key stakeholders (and residents if you are taking a Co-Production approach) is an important early deliverable in your project.</p> <p>Measurement is a critical part of knowing if we have made a difference, what the impact of the changes are, if we have met our aim, and future action to take.</p> <p>There are three types of Measures you may want to consider when agreeing your measures:</p> <table border="1" data-bbox="341 1615 1374 1953"> <thead> <tr> <th data-bbox="341 1615 687 1648">Outcome</th> <th data-bbox="687 1615 1034 1648">Balance</th> <th data-bbox="1034 1615 1374 1648">Process</th> </tr> </thead> <tbody> <tr> <td data-bbox="341 1648 687 1953">Outcome measures link back to the numeric goal within the aim statement. They can also indicate how the system is working, specifically the impact on residents.</td> <td data-bbox="687 1648 1034 1953">Balance measures demonstrate that parts/steps in the system are performing as planned. They can also demonstrate whether you are on track in your efforts to improve the system</td> <td data-bbox="1034 1648 1374 1953">Process measures can demonstrate changes designed to improve one part of the system, causing new problems in other parts of the system</td> </tr> </tbody> </table> 	Outcome	Balance	Process	Outcome measures link back to the numeric goal within the aim statement. They can also indicate how the system is working, specifically the impact on residents.	Balance measures demonstrate that parts/steps in the system are performing as planned. They can also demonstrate whether you are on track in your efforts to improve the system	Process measures can demonstrate changes designed to improve one part of the system, causing new problems in other parts of the system
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	<p>Example for an access project: Number of days to 3rd next available appointment</p>	<p>Example for an access project: Average daily clinician hours available for appointments</p>	<p>Example for an access project: Making sure A&E attendances are not increasing</p>
<p>(4) Agree Change Ideas</p>	<p>Once you have agreed your Measures, you can use this to support identifying your Drivers in your Driver Diagram.</p> <p>Once we have agreed an Aim and Measures, you will need to agree your Change Ideas.</p> <p>As per the Model for Improvement diagram on the right, agreeing change ideas helps us answer the ‘What change can we make that will result in improvement?’ question.</p> <p>Identifying and agreeing Change Ideas with your key stakeholders (and residents if you are taking a Co-Production approach) is an important early deliverable in your project.</p> <p>There isn’t any one right way of identifying and agreeing Change Ideas within a service change, it depends on the type of service change. If you are taking a Co-Production / Co-Design type approach then lots of engagement with residents is a good idea, which could be on a 1-2-1 basis, in small groups or in large groups.</p> <p>Any Change Ideas you identify and agree at this stage will support the completion of the Driver Diagram (next step) and later on in this stage, the Business Case.</p>		
<p>(5) Create a Driver Diagram</p>	<p>At this point, you should have an Aim, Measures (to support the identification of Drivers) and Change Ideas. The next step is to plot them on a Driver Diagram.</p> <p>A Driver Diagram is a visual display of a team’s theory of what “drives,” or contributes to, the achievement of a project aim. This clear picture of a team’s shared view is a useful tool for communicating to a range of stakeholders where a team is testing and working.</p> <p>Depending on the type of service change, it would be beneficial to create your Driver Diagram with ICB colleagues, provider colleagues and residents (depending on the level of Co-Production or Co-Design) to ensure all views are reflected in the final product.</p> <p>Make sure your SRO is happy with your Driver Diagram. The Driver Diagram is not a ‘boundary checkpoint’ type deliverable, or mandatory document that requires sign-off, but it is an important tool, and something that key stakeholders and your SRO need to agree on.</p> <p>If you need help creating a Driver Diagram, there are many tutorials on the internet to watch – the IHI website has some good tutorials - https://www.ihl.org/resources/tools/driver-diagram</p>		





Internally you can speak to the QI team, STT or PMO who can all support with Driver Diagrams. The PMO have a template for Driver Diagrams.

(6) Create a QIA, EQIA, HEAT, DPIA & EaSIA

Once you know your Change Ideas, you will begin to have a better understanding of the totality of the change you are proposing to make.

It is now important you explore what potential holistic impact your proposed changes could have on:

- Safety
- Clinical Effectiveness
- Resident Experience and Involvement
- Protected Characteristics
- Human Rights
- Health Inequalities
- Socio-economic status or geographic deprivation
- Inclusion health and vulnerable groups (for example, people experiencing homelessness, prison leavers, young people leaving care)
- Processing Data
- Accessing Data
- Safe Practice (Information Governance)
- Environmental degradation and climate change
- Socio-economic development

All the above considerations are covered in the following Impact Assessments.

All Impact Assessments are available from the PMO Intranet page - <https://intranet.bedfordshirelutonandmiltonkeynes.icb.nhs.uk/programme-management-office-pmo>

Impact Assessment	Description	Lead Team
<p>Quality Impact Assessment (QIA)</p>	<p>The Quality Impact Assessment (QIA) has been developed to ensure that BLMK ICB has the appropriate steps in place to safeguard quality whilst delivering significant changes to service delivery. This process should be used to assess the impact that any service may have on the quality of care provided to the population of BLMK.</p> <p>The QIA supports quality governance by assessing the impact on quality from three key perspectives, Safety, Clinical Effectiveness and Patient & Resident Experience & Involvement.</p>	<p>ICB Quality Team - -- blmkicb.bedsqualityteam@nhs.net</p>
<p>Review & Approval Process (Due Diligence)</p>		
<p>A QIA must be undertaken with the Quality Team, appraised by the Clinical Advisory Group (CAG) and approved by the SRO before any decisions can be made or any Business Case agreed, that could potentially impact on services.</p> <p>All QIAs need to be registered with the PMO Team before they are started.</p> <p>You need to complete the Screening Tool first, to determine whether a full QIA is needed. If you are unsure as to whether a full QIA is needed, or you would like to know who in the Quality Team is best placed to support, please contact the Quality Team.</p>		
<p>Equality Impact Assessment Tool (EQIA) and Health Equity Assessment Tool (HEAT)</p>	<p>The purpose of an EQIA and HEAT is to ensure that services, policies and practices do not directly, indirectly, intentionally or unintentionally discriminate against the users of services, or on staff. Undertaking an EqIA enables the ICB to consider the impact of</p>	<p>AGEM Equality, Diversity, and Inclusion Team - agcsu.equality@nhs.net</p>

		<p>each current and proposed service, policy, procedure or function, not only with regard to ethnicity, disability, age and sex, but also in relation to religion and belief, sexual orientation, and human rights. It is designed to ensure that 'due regard' is given to equality in relation to service users and the manner in which we recruit, train and develop staff</p>	
		<p>Review & Approval Process (Due Diligence)</p>	
		<p>EQIA/HEAT must be undertaken with the AGEM Equality, Diversity, and Inclusion Team, appraised by the Clinical Advisory Group (CAG) and approved by the SRO before any decisions can be made or any Business Case agreed, that could potentially impact on services.</p> <p>All EQIA/HEAT need to be registered with the PMO Team before they are started.</p> <p>You need to complete EQIA/HEAT Stage 1, to determine whether EQIA/HEAT Stage 2 is needed. If you are unsure as to whether EQIA/HEAT Stage 2 is needed, or you would like to know more on EQIA/HEATs then speak to the AGEM Equality, Diversity, and Inclusion Team.</p>	
	<p>Data Protection Impact Assessment (DPIA)</p>	<p>A DPIA is a process which helps to identify privacy risks to individuals (data subjects) in the processing of their information/data e.g. viewing, transferring, obtaining, using, sharing, collating, storing etc</p>	<p>ICB Safe Practice Team - icb.ig@nhs.net</p>
		<p>Review & Approval Process (Due Diligence)</p>	
		<p>If you are starting a new service change which involves the processing of personal identifiable information, e.g., installing a new IT system, implementing a new process, changing a process, sharing information, starting a new service or making changes to an existing service, you may need to complete a DPIA.</p> <p>To establish if you need to complete a DPIA you will need to complete the Stage One Screening Questionnaire template.</p>	

	<p>If the results of Stage One indicates that a DPIA is required, then you are legally required to complete a Stage Two DPIA template.</p> <p>Staff Guidance for completion of the Stage One or Stage Two DPIA Template is available via the Intranet.</p> <p>Stage One DPIA does not require approval but Stage Two may require approval from the Data Protection Officer, Senior Information Risk Owner (SIRO) and Caldicott Guardian.</p>	
<p>Environmental and Social Impact Assessment (EaSIA)</p>	<p>The EaSIA helps consider the wide range of possible impacts that a proposed project could have on the building blocks of health. It supports identifying the impact on statutory and related duties from the Health and Care Act pertaining to environment and social factors.</p>	<p>ICB Sustainability & Growth Team – tim.simmance@nhs.net or sian.pither@nhs.net</p>
	<p>Review & Approval Process (Due Diligence)</p>	
	<p>For support on completing the EaSIA tool please speak to Tim or Sian - tim.simmance@nhs.net & sian.pither@nhs.net.</p> <p>All service changes need to complete an EaSIA.</p> <p>The EaSIA can be completed without the involvement of the Sustainability & Growth Team, however, it needs to be reviewed and appraised by the Sustainability & Growth Team.</p> <p>Approval of the EaSIA is by the SRO and Sustainability & Growth Team before any decisions can be made or any Business Case is agreed.</p> <p>All EaSIAs need to be registered with the Sustainability & Growth Team before they are started.</p>	
<p>Depending on the type service change, you may not need to complete all the Impact Assessments.</p> <p>For example, if you are commissioning a new Internal Expenses IT System, you may only need to complete a DPIA as this will not directly impact on how or where residents access services but does require data to be processed safely – however, if you are commissioning a new MSK service, you may need to complete all 4 Impact Assessments, as it may impact on how and where residents access services.</p> <p>If you are unsure on whether an Impact Assessment is required for your project, please contact the lead teams in the table above.</p> <p>Additional guidance on completing the Impact Assessments is available within the templates via the Intranet.</p>		

	<p>QIA, EQIA and HEAT will need to be appraised by the Clinical Advisory Group (CAG) before they can accompany the Business Case when a decision is sought – see next section.</p> <p>The DPIA and EaSIA do not need to go to CAG but do need to accompany the Business Case when a decision is sought.</p> <p>Sign-off for each of the Impact Assessments is explained within the templates – in most cases the Impact Assessments need to be signed-off by the SRO before they can go to CAG.</p>
<p>(7) Create a Business Case or Project Initiation Document (PID)</p>	<p>So, you now have your Need for Change Evidence Base, Aim, Measures, Change Ideas, Requirements, Driver Diagrams and Impact Assessments – the next step is to pull all this information together into a Business Case.</p> <p>The Business Case provides the optimum mix of information used to judge whether the project is (and remains) beneficial, viable and achievable, and therefore worthwhile investing time and/or money in.</p> <p>It is also the means of obtaining organisational commitment and is a baseline to measure success against.</p> <p>Before taking any Business Case for approval it must be well socialised and have been endorsed by key supportive functions such as PMO, Finance, Quality & Safeguarding, Sustainability and Growth, VCSE, Communications & Engagement, Contracting, Information Governance and People & Development.</p> <p>Without this endorsement, you will be unlikely to get approval.</p> <p>More information on support for Business Case writing is available on the PMO Intranet Page. The template is available from the Intranet - https://intranet.bedfordshirelutonandmiltonkeynes.icb.nhs.uk/programme-management-office-pmo</p> <p>For some smaller projects, a Business Case is not always required. Instead a smaller 2-page Project Initiation Document (PID) can be completed. For example, for in-year Financial Recovery schemes or smaller pilots.</p> <p>As a rule of thumb, if a project has a lifetime cost of less than £100k and the proposal does not materially change how or where residents access services, then a Business Case is not required – and instead a PID can be completed.</p> <p>The PID template is available from the Intranet - https://intranet.bedfordshirelutonandmiltonkeynes.icb.nhs.uk/programme-management-office-pmo</p> <p>Business Case and PID approval is covered in the next section.</p>
<p>(8) Obtain clinical and ethical steer from CAG</p>	<p>If you have completed a QIA, EQIA, HEAT they will require appraisal from the Clinical Advisory Group prior to a request for a decision.</p> <p>Clinical Advisory Group (CAG) provides strategic clinical leadership and guidance across the ICB, to inform the ICB's decisions. It may receive recommendations from the Senate to inform its work.</p>

	<p>Its key remit is to provide clinical and care professional evidence-based advice and make recommendations on service transformation for issues which impact across the ICB footprint.</p> <p>The CAG will not routinely be involved in issues which relate solely to individual Place-level transformation, which will be dealt with by the four BLMK ICB Place-Based Partnerships as set out in their terms of reference and the ICB's scheme of reservation and delegation.</p> <p>The CAG will process business regarding transformation and efficiencies in ICB commissioning and clinical prioritisation.</p> <p>CAG provides a recommendation from clinical and ethical perspective on the most contentious proposals, such as disinvestments or decommissioning.</p> <p>Any feedback or recommendations from CAG, needs to be reflected in the Impact Assessments and the Business Case before they are taken for a decision.</p>
(9) Commence Co-Design	<p>If you have chosen to adopt Co-Design for your service change, it is at this stage you will want to begin engaging with residents.</p> <p>For more information on how best to engage with residents early on, speak to the Communications & Engagement Team.</p>

The Service Change Methodology Explained	
Initiation	
Expectation	Description of Expectation
(1) Determine Engagement Route	<p>By the point of Initiation you may have already started your resident engagement journey, as both Co-Production and Co-Design are covered in the previous two stages.</p> <p>However, if you haven't started your resident engagement journey, this section will support with which route you may take.</p> <p>Importance of Resident Engagement</p> <p>When services change or new services are needed it is important that the needs of our whole community are considered. We can only make sure this happens by listening to all voices involved in using and delivering the service. This means our services will be better tailored to our community needs, and makes sure they are accessible to everyone who needs to use them to deliver the best outcomes for our community. Involving our whole community in creating healthcare services can help our whole community to become healthier together and improve the experiences of delivering services. Resident engagement is a legal obligation of the ICB under the Health & Care Act 2020 and comes in the forms of Co-Production, Co-Design, Co-Evaluation and Informing.</p> <p>Types of Resident Engagement</p> <ul style="list-style-type: none"> • Co-Production – an equal partnership where residents with lived and learnt experience work together on a service change proposal from start to finish.

- **Co-Design** – designing with people and incorporating their ideas into the final approach to making a proposed service change.
- **Co-Evaluation** – where the service already exists, and you are working with residents with lived and learnt experience to evaluate it.
- **Engagement** – listening to residents to understand issues and discuss ideas for change.
- **Consulting** – asking for resident opinions on one or more ideas or options.
- **Informing** – sharing information about proposed changes so residents understand what they mean.



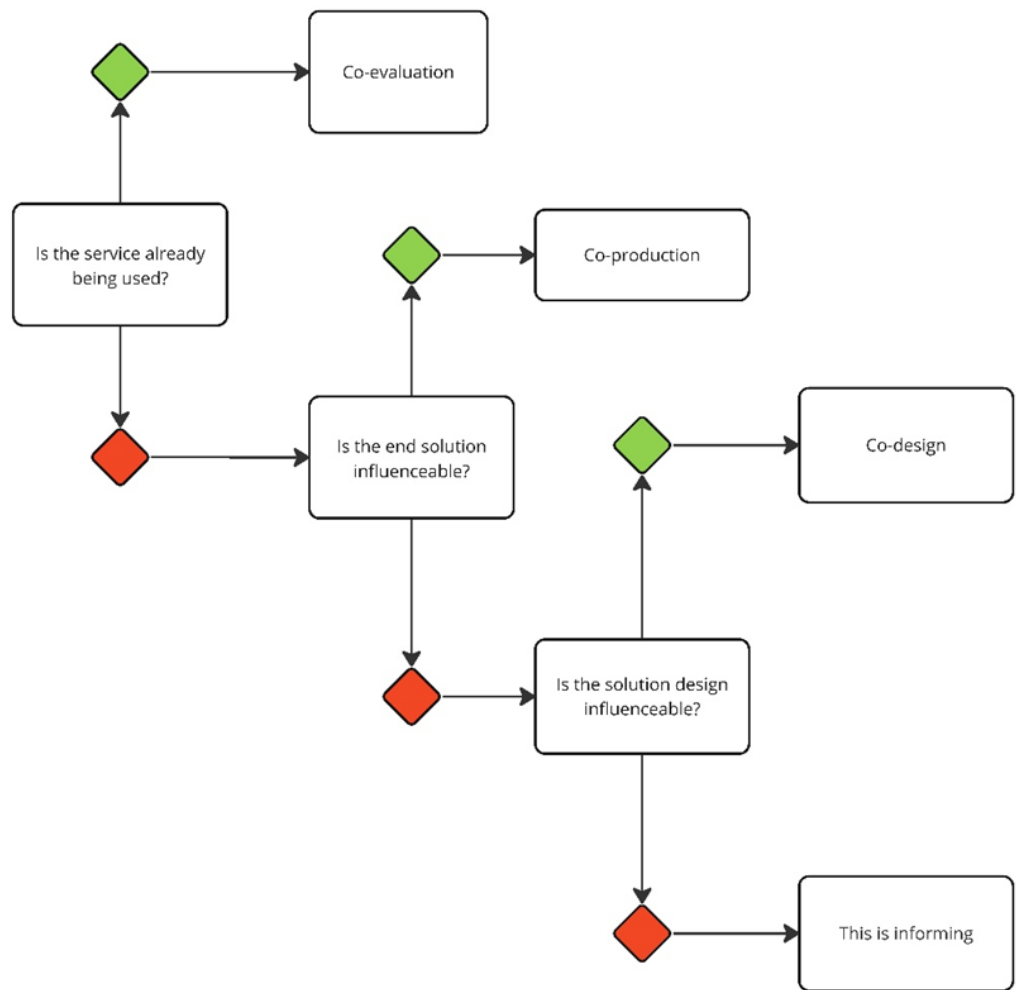
Your Resident Engagement Journey

Co-production starts with a “problem to be solved” rather than a “solution to be shared”. If we are co-producing healthcare, that means bringing everyone together to understand the overall issues, and then building a solution using everyone’s talents and resources.

If we consider co-production as a cycle, we can start our journey anywhere on it, but if we are truly co-producing, we will have gone through all of stages. This means some projects will start at co-design, and as community relationships develop, eventually become co-produced as those solutions are evaluated, and developed or changed completely in favour of more suitable solutions.

But for our healthcare to be truly co-produced, everyone affected will be involved from the beginning.

The diagram below might help you to think about some key questions to find where your resident engagement journey could start



If you have any questions about what method of Resident Engagement you feel is most appropriate to your project, then speak to the Communications & Engagement Team.

(2) Undertake engagement route

Your resident engagement should be guided by this Policy and more importantly the Working with People & Communities Strategy.

Our Working with People & Communities Strategy sets out how working with people and communities supports the wider objectives of integration including population health management, personalisation of care and support, addressing health inequalities and improving quality. It supports our organisation to build collaborative and meaningful partnerships that start with people and focus on what really matters to our communities.

There are clear benefits to working in partnership with people and communities. It means better decisions about service changes and how money is spent. It reduces risks of legal challenges and improves safety, experience and performance. It helps address health inequalities by understanding

	<p>communities' needs and developing solutions with them. It is about shaping a sustainable future for the NHS that meets people's needs and aspirations.</p> <p>To support your engagement with residents, you can create a Communications Plan. A Communications plan sets out how you will engage with residents and when.</p> <p>Another useful tool with regards to resident engagement is a Stakeholder Matrix or Map.</p> <p>A Stakeholder Matrix or Map enables you to identify everyone who needs to be involved and assess how much time and resources to give to maintaining their involvement and commitment.</p> <p>Both the Communications Plan and Stakeholder Matrix or Map templates are available from the Intranet and Verto 365.</p>
(3) Visiting OSCs & H&WBBs	<p>If your service change is changing how or where residents access services you will likely need to go to one or more Overview and Scrutiny Committees (OSCs) and Health & Wellbeing Boards (H&WBBs).</p> <p>All four Places have an OSC – Bedford, Central Bedfordshire, Luton and Milton Keynes.</p> <p>Three of the Places have a H&WBB – Bedford, Central Bedfordshire and Luton, while Milton Keynes has a Health & Care Partnership.</p> <p>You will need to go to an OSC and H&WBB where you are impacting on residents of that Place.</p> <p>What is expected of you when you do attend an OSC or H&WBB is likely to be an 'off-the-agenda briefing' as a minimum – however if your service change is proposing more contentious changes, then you may be asked to present your case at the OSC or H&WBB and be open to questions from residents.</p> <p>For more information on OSCs and H&WBBs please speak to the Communications and Engagement Team.</p>
(4) Possible NHSE & Secretary of State	<p>NHS England Requests</p> <p>ICBs have delegated limits of expenditure, which in a majority of smaller/medium sized service change is covered under these delegated limits.</p> <p>However for larger service change, such as service transformation, you may need to get NHS England approval – this process is managed by the NHS England Project Appraisal Unit.</p> <p>The NHS England Project Appraisal Unit is a small specialist central team within NHS England Strategic Finance comprising of experienced capital investment and estates professionals who will be available to provide support to officers of NHS England at local Director of Commissioning Operations (DCO) offices, Sustainability and Transformation Partnerships, Regional Team, Commissioning Support Units, Commissioning Support Unit Transition Team (CSUTT) and National Team levels, and to ICBs.</p> <p>Full explanation of the process is detailed here - https://www.england.nhs.uk/wp-content/uploads/2018/10/a1p-nhse-bc-approvals-guide.pdf</p>

The below table summarises the thresholds used by NHSE:

Investments < £1m	There is a streamlined process for sanctioning most investments of less than £1m on a batched basis via use of a proforma schedule of key information. The Project Appraisal Unit can provide further advice and guidance on use of this process and when it may be applied. It should be noted that use of the streamlined process for sanctioning investments of less than £1 million does not remove the requirement for approving officers to assure themselves that appropriate rigour and analysis underpins the plans for any such investments.
Business Cases between £1 million and £3 million in value	Business Case requirements for investments in this value range will vary depending on the complexity of the proposition. In many cases a Business Justification Case will be sufficient, and a template is available from the Project Appraisal Unit. This is closely modelled on the HM Treasury Five Case Model template and provides a means of articulating the investment proposals in a single submission following approval of the PID. It should be noted that this approach will not be sufficient in all cases, and there will be circumstances when an alternative approach is more appropriate. The Project Appraisal Unit can provide advice and guidance to support project sponsors in deciding on the appropriate approach for individual projects
Business Cases >£3 million	Business cases at a value of greater than £3 million should be developed and submitted using the Outline Business Case and Full Business Case approach in accordance with HM Treasury Green Book and Five Case Model requirements.

Secretary of State Requests

His Majesty's principal Secretaries of State, or Secretaries of State, are senior ministers of the Crown in the Government of the United Kingdom. Secretaries of State head most major government departments and make up the majority of the Cabinet of the United Kingdom.

The Secretary of State can at any point request a review of any service change – so therefore as an organisation we need to be prepared should this happen.

(5) Agreeing a recommended option

This step has been singled out, to remind project leads of the importance of your recommended option reflecting your engagement findings and user requirements.

When you have agreed your recommended option, you can revisit your Business Case and Impact Assessments to ensure they are still relevant, up-to-date and reflect your resident engagement findings.

(6) Business Case or Project Initiation Document (PID) approval

See below **Service Change Decision-Making Matrix**.

Depending on the (1) total lifetime cost of your service change and (2) how your service change impacts on how or where residents access services, the matrix below provides what deliverables are required and where the deliverables need to get appraised and approved.

	<p>Where deliverables are taken for appraisal and approval is based on the Governance Handbook, Scheme of Reservation & Delegation and Standing Financial Orders (SFIs).</p> <p>The grid also includes like-for-like contract renewals, which are based on the SFIs from the Governance Handbook, for completeness.</p>
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**Bedfordshire, Luton
and Milton Keynes
Integrated Care Board**

Service Change Decision-Making Matrix

Type of work being proposed	Total life of contract value	Impact on how or where residents access services	Driver Diagram	PID	Business Case	QIA	EQIA & HEAT	DPIA	EaSIA	CAG	Operational Group, Exec Group, IVOG (under SFIs)	FIC	Q&PC	OSC & HWBBs	NHSE	Board of the ICB	
Decommissioning an Existing Service	Any	Significant	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
		Moderate	✓	X	✓	✓	✓	✓	✓	✓	✓	X	X	X	X	X	
		Negligible	✓	X	✓	X	X	X	X	X	X	✓	X	X	X	X	X
Commissioning a New Service	>£3m	Any	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	£500k-£3m	Any	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	
		Significant	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
		Moderate	✓	X	✓	✓	✓	✓	✓	✓	✓	X	X	X	X	X	
	£500k-£100k	Significant	✓	X	✓	X	X	X	X	X	X	✓	X	X	X	X	X
		Moderate	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	X	X	X	X	X
		Negligible	✓	X	✓	X	X	X	X	X	X	✓	X	X	X	X	X
	<£100k	Significant	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
		Moderate	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	X	X	X	X	X
Negligible		✓	✓	X	X	X	X	X	X	X	✓	X	X	X	X	X	
Making Changes to an Existing Service	>£3m	Any	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	£500k-£3m	Any	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	
		Significant	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
		Moderate	✓	X	✓	✓	✓	✓	✓	✓	✓	X	X	X	X	X	
	£500k-£100k	Significant	✓	X	✓	X	X	X	X	X	X	✓	X	X	X	X	X
		Moderate	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	X	X	X	X	X
		Negligible	✓	X	✓	X	X	X	X	X	X	✓	X	X	X	X	X
	<£100k	Significant	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
		Moderate	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	X	X	X	X	X
Negligible		✓	✓	X	X	X	X	X	X	X	✓	X	X	X	X	X	
Renewing Existing Contracts	>£3m	N/A	X	X	X	X	X	X	X	X	✓	✓	X	X	X	✓	
	£500k-£3m		X	X	X	X	X	X	X	X	✓	✓	X	X	X	X	
	£100k-£500k		X	X	X	X	X	X	X	X	X	✓	X	X	X	X	X
	<£100k		X	X	X	X	X	X	X	X	X	✓	X	X	X	X	X

The Service Change Methodology Explained

Implementation

Expectation	Description of Expectation
<p>(1) Provider Selection Regime (PSR)</p>	<p>This section of the Policy is not meant to replace any Procurement or Contracting Strategy, and only scratches the surface of Procurement and Contracting requirements. For more information, please speak to the ICB Contracting Team or AGEM Procurement Team.</p> <p>The NHS Provider Selection Regime (PSR) replaced all other processes in England for healthcare services procurement by relevant authorities on 01 January 2024.</p> <p>The PSR The PSR applies to the arrangement of health care and public health services arranged by relevant authorities and irrespective of who the provider is (i.e., whether the service is provided by NHS providers, other public sector bodies, local authorities, or providers within the voluntary, community, social enterprise (VCSE) and independent sectors).</p> <p>The PSR does not apply to goods and non-healthcare services (such as medicines, medical equipment, cleaning, catering, business consultancy services and social care), unless arranged as part of mixed procurement.</p> <p>Relevant authorities can follow three different provider selection processes to award contracts for health care services under the PSR:</p> <ol style="list-style-type: none"> 1. Direct award processes (direct award process A, direct award process B and direct award process C) 2. Most suitable provider process. 3. Competitive process. <p>The Direct Award Processes</p> <p>These involve awarding contracts to providers when there is limited or no reason to seek to change from the existing provider; or to assess providers against one another, because:</p> <ul style="list-style-type: none"> • The existing provider is the only provider that can deliver the health care services (direct award process A) • Patients have a choice of providers, and the number of providers is not restricted by the relevant authority (direct award process B) • The existing provider is satisfying its existing contract, will likely satisfy the new contract to a sufficient standard, and the proposed contracting arrangements are not changing considerably (direct award process C). <p>There are three potential direct award processes (A, B, C). Further detail is outlined below.</p> <p>Direct award process A must be used when all of the following apply:</p>

- There is an existing provider of the health care services to which the proposed contracting arrangements relate.
- The relevant authority is satisfied that the health care services to which the proposed contracting arrangements relate can only be provided by the existing provider (or group of providers) due to the nature of the health care services.

Direct award process A must not be used to conclude a framework agreement.

Direct award process B must be used when all of the following apply:

- The proposed contracting arrangements relate to health care services where patients are offered a choice of provider.
- The number of providers is not restricted by the relevant authority.
- The relevant authority will offer contracts to all providers to whom an award can be made because they meet all requirements in relation to the provision of the health care services to patients.
- The relevant authority has arrangements in place to enable providers to express an interest in providing the health care services.

Where relevant authorities are required to offer choice to patients under the 'National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012', they cannot restrict the number of providers and therefore direct award process B must be followed.

Direct award process B must not be used to conclude a framework agreement.

Direct award process C may be used when all of the following apply:

- The relevant authority is not required to follow direct award processes A or B
- The term of an existing contract is due to expire, and the relevant authority proposes a new contract to replace the existing contract at the end of its term.
- The proposed contracting arrangements are not changing considerably.
- The relevant authority is of the view that the existing provider (or group of providers) is satisfying the existing contract and will likely satisfy the proposed contract to a sufficient standard.

Direct award process C must not be used to conclude a framework agreement.

The Most Suitable Provider Process

This involves awarding a contract to providers without running a competitive process, because the relevant authority can identify the most suitable provider.

This provider selection process may be used when all of the following apply:

- The relevant authority is not required to follow direct award processes A or B
- The relevant authority cannot or does not wish to follow direct award process C.
- The relevant authority is of the view, taking into account likely providers and all relevant information available to the relevant authority at the time, that it is likely to be able to identify the most suitable provider (without running a competitive process).

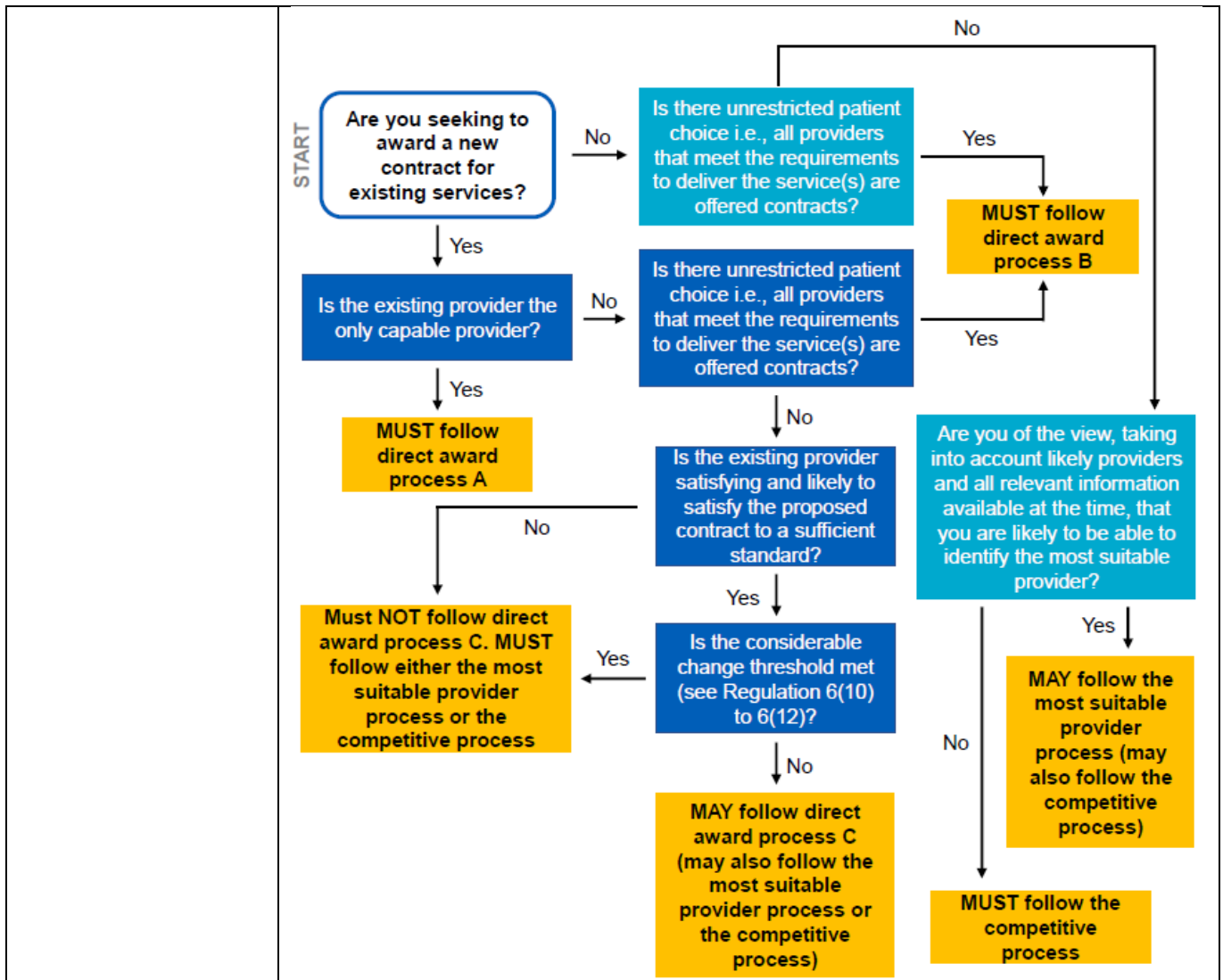
The most suitable provider process must not be used to conclude a framework agreement.

The Competitive Process

This involves running a competitive process to award a contract. This provider selection process must be used when all of the following apply:

- The relevant authority is not required to follow direct award processes A or B
- The relevant authority cannot or does not wish to follow direct award process C, and cannot or does not wish to follow the most suitable provider process.

The following process map may help with which route to take:



It is recommended you seek AGEM Procurement advice before applying the PSR for your project.

(2) Creating a Service Specification

At this point you would create and agree the Service Specification (or equivalent deliverable that sets out what you want from a provider).

The Service Specification is developed as the primary means of designing and agreeing key performance indicators (both their type and means of measure), service level agreements and contracts.

Development of the Service Specification is a necessary pre-requisite for the contracting and tendering process

(3) Contract Variations

If you are wanting to make changes to existing services or contracts mid-contract duration, then you can use Contract Variations.

Any proposed Variation should be considered in the context of the contract as a whole, and in the context of wider procurement, competition and other issues, and not in isolation.

Note in particular that a Variation may constitute a “material change” to the contract, thereby raising the risk of a challenge for breach of procurement rules.

	For more information on using Contract Variations please speak to the ICB Contracting team.
(4) If Decommissioning – Serve Notice	<p>To serve notice to an NHS service provider, start by reviewing the terms of your contract or service agreement, which will outline the specific requirements for notice, including duration and method of communication.</p> <p>Draft a formal letter that clearly states your intention to terminate the service, including your name, contact information, the date of the notice, and relevant details about the service being terminated. Be sure to specify the last date of service and any other pertinent information, such as outstanding payments or arrangements for the transition.</p> <p>Deliver the notice via a method stipulated in the contract, such as registered mail or email, ensuring you keep a copy for your records. It may also be helpful to follow up with a phone call to confirm receipt.</p> <p>For more information speak to the ICB Contracting team.</p>

The Service Change Methodology Explained

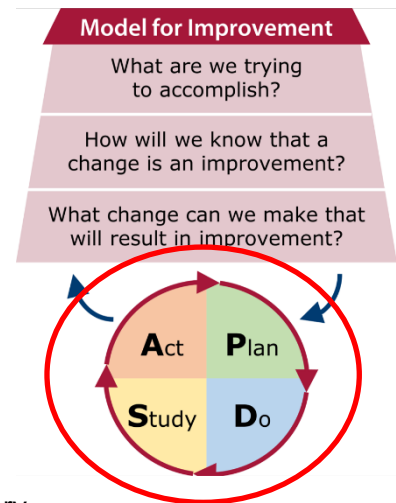
Mobilisation & Go-Live

Expectation	Description of Expectation
(1) Mobilisation	<p>Once a provider is secured the next step is mobilisation.</p> <p>Mobilisation or service implementation planning is concerned with the practical planning around the change in service; not the planning relating to project delivery.</p> <p>It is recommended the Project Manager co-produces a mobilisation plan with the provider, and holds the provider to account via the Project Board until fully mobilised.</p>
(2) Go Live	At this point the new service or service change is live.
(3) If Decommissioning – Create a Decommissioning Plan	<p>Creating a plan for decommissioning an NHS provider involves several key steps – most of which have been covered in earlier sections of this policy.</p> <p>First, assess the current services and their impact on patient care, considering factors like patient volume, quality of care, and financial performance.</p> <p>Engage stakeholders, including staff, patients, and community representatives, to gather input and ensure transparency.</p> <p>Develop a timeline that outlines the phases of decommissioning, including communication strategies to inform all parties about the changes.</p> <p>Identify alternative services or providers to ensure continuity of care for patients.</p> <p>Finally, implement monitoring and evaluation processes to assess the impact of decommissioning and make adjustments as necessary, ensuring that patient safety and care standards remain a priority throughout the transition.</p>
(4) If Decommissioning – Service Terminates	At this point the existing service has terminated.

The Service Change Methodology Explained

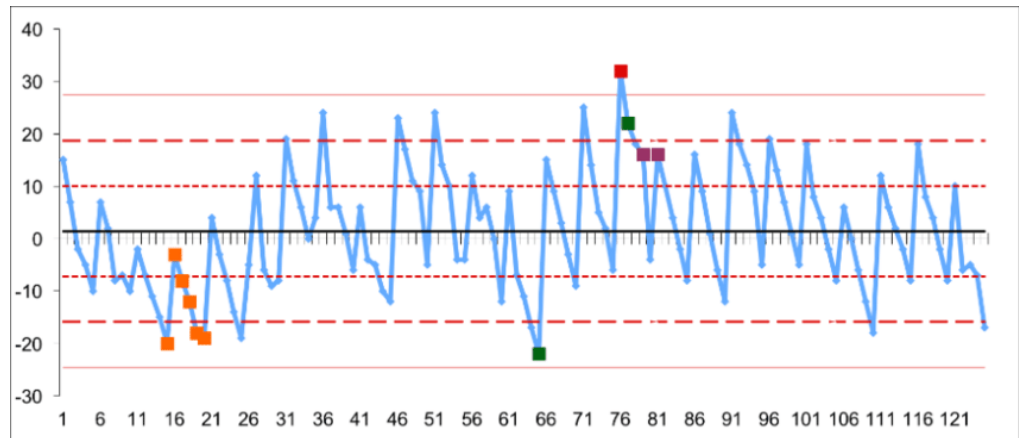
Testing, Monitoring & Closure

Expectation	Description of Expectation
<p>(1) Using PDSA to test the Service Change is Implemented Effectively.</p>	<p>Once the service is live, the project should remain active whilst you are monitoring its performance against the agreed measures.</p> <p>Only once all the improvements you agreed at the beginning of the project are being achieved and sustained, can you close the project, conduct a lessons learnt, and finally hand the work over as Business as Usual (BAU).</p> <p>As per the Model for Improvement diagram on the right, this is where you would be overseeing the changes you have introduced, studying that these changes are resulting in improvements and making adaptations if necessary.</p> <p>This process can be supported using Plan-Do-Study-Act (PDSA) cycles.</p> <p>The Plan-Do-Study-Act (PDSA) method is a way to test a change that is implemented and is about “learning through doing”. Going through the prescribed four steps guides the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again. Most of us go through some or all of these steps when we implement change in our lives, and we don't even think about it.</p> <p>Early PDSA cycles should be on as small a scale as possible to allow rapid learning and to minimise the unexpected consequences of changing a system. Later PDSA cycles should be about testing how well a change can be sustained.</p> <p>Plan</p> <p>Think about how you plan on testing the newly Commissioned service, decommissioned service, or service change. What do you need to know from those that run the service or service users to test whether the changes you have introduced are leading to improvements. Document your plan.</p> <p>Do</p> <p>After you have your plan, you will need to execute it or set it in motion. This could be observing the changes, sending out surveys or questionnaires, Menti Polls etc. The Do part ensures you are testing your newly commissioned service, decommissioned service, or service change.</p> <p>Study</p> <p>Here is where you study what the testing has revealed – did it achieve the goals you set out?</p>



One useful tool in Studying is using **Statistical Process Control (SPC) charts**.

SPC charts are a line graph showing a measure in chronological order, with the measure on the vertical (y) axis and time or observation number on the horizontal (x) axis. See below example:



The average of the data is shown as the centre line. Sigma limits are also shown, which are calculated based on a measure of variation (called “standard deviation”) in the data (sigma). These limits show what range we can expect most future data points to be in based on the variation seen in the data if the process is stable and therefore predictable.

Changes made to a process, and other useful annotations, are also often marked on the graph so that they can be connected with the impact on the process.

There are different types of SPC charts depending on the type of data you have.

The most common ones are:

P chart – for classification data expressed as a % or proportion

I chart (or Xmr chart) – for individual measurements

C chart – count data – for numbers of incidents (or U chart if expressed as a rate)

Xbar & S chart – for measurements data where an average can be calculated at each time point.

For help with SPC charts, speak to the ICBs QI Team.

Act

This step is a critical part of “learning through doing”. Here you will write what you learned during this cycle of implementation, whether it worked or not. Learning should be captured as you go within a Lessons Learnt log. If the cycle did not work as expected, you will be learning what you can do differently in your next cycle of testing. If it did work, you can capture why it worked as expected. At the end of each cycle, you are ready to **Adopt, Adapt or Abandon** the change idea.

For any support with PDSA cycles, speak to the ICBs QI Team.

<p>(2) Lessons Learnt & Closure</p>	<p>Project closure should be documented in the Closure Report.</p> <p>The Closure Report provides an assessment of success (based on what the Business Case set out), handover to BAU and lessons learnt.</p> <p>A key part of closure is to ensure performance / BAU KPIs are established, and that performance is monitored going forward.</p> <p>PMO would recommend socialising lessons learnt so that any future projects can learn from both the successes and the failures of a project. If any additional lessons learnt documentation/reports are produced, these need to be shared with the PMO for organisational memory.</p> <p>Lessons learnt can also be shared on Verto 365.</p> <p>The Closure Report would be supported, appraised and approved by your Project Group.</p> <p>Following approval of the Closure Report, any remaining actions, risks or benefits monitoring needs to be handed over to BAU. Once completed the Project Team and Project Group can be disbanded.</p>
<p>(3) Commence Co-Evaluation</p>	<p>If you have chosen to adopt Co-Evaluation for your service change, it is at this stage you will want to begin engaging with residents.</p> <p>For more information on how best to engagement with residents for evaluation, speak to the Communications & Engagement Team.</p>

Appendix 1 - Equality Impact Assessment Initial Screening

Please answer the questions against each of the protected characteristic and inclusion health groups. If there are significant impacts and issues identified a full Equality / Quality Impact Assessment (EQIA) must be undertaken.

It is against the law to discriminate against someone because of these protected characteristics.

For support and advice on undertaking EQIAs please contact: agcsu.equalities@nhs.net

Name of Policy:	Programme & Project Management Framework Policy
Date of assessment:	23/09/2024
Screening undertaken by:	Matt Hollex – Head of PMO

Protected characteristic and inclusion health groups. Find out more about the Equality Act 2010, which provides the legal framework to tackle disadvantage and discrimination: https://www.equalityhumanrights.com/en/equality-act/protected-characteristics	Could the policy create a disadvantage for some groups in application or access? (Give brief summary)	If Yes - are there any mechanisms already in place to mitigate the potential adverse impacts identified? If not, please detail additional actions that could help. If this is not possible, please explain why
<p>Age A person belonging to a particular age (for example 32 year olds) or range of ages (for example 18 to 30 year olds).</p> <p>Disability A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.</p> <p>Gender reassignment The process of transitioning from one gender to another.</p> <p>Marriage and civil partnership Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'.</p> <p>Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked</p>	<p>No - the Programme & Project Management Framework Policy mandates the use of EQIA and HEAT for all commissioning, decommissioning and service change work being proposed. Both EQIA and HEAT ensure all change proposals consider protected characteristics, fairness, and equity.</p>	<p>N/A</p>

<p>to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.</p>		
<p>Race Refers to the protected characteristic of race. It refers to a group of people defined by their race, colour and nationality (including citizenship) ethnic or national origins.</p>		
<p>Religion or belief Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.</p>		
<p>Sex A man or a woman.</p>		
<p>Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex, to both sexes or none.</p>		
<p>Carers Individuals within the ICB which may have carer responsibilities.</p>		
<p>Please summarise the improvements which this policy offers compared to the previous version or position.</p>		
<p>Heightened awareness of the EQIA and HEAT impact assessment and there importance in commissioning, decommissioning and service change.</p>		
<p>Has potential disadvantage for some groups been identified which require mitigation?</p>		
<p>No</p>		

Appendix 2 - Data Protection Impact Assessment Initial Screening

Data protection is the fair and proper use of information about people. Before completing this form, please refer to the Data Protection Impact Assessment (DPIA) Guidance in the Information Governance (IG) section on the staff Intranet or contact the Data Protection Officer for support via blmkccg.ig@nhs.net

A DPIA is a process to help you identify and minimise the data protection risks. You must do a DPIA for processing that is likely to result in a high risk to individuals. You can use our screening checklist below to help you decide when to do one. If you have answered 'Yes' to any of the 10 screening questions, you must then carry out a full DPIA using the Stage 2 form, which is also available on the Intranet in the IG section.

Name of Policy:	Programme & Project Management Framework Policy
Date of assessment:	23/09/2024
Screening undertaken by:	Matt Hollex – Head of PMO

Stage 1 – DPIA form

please answer 'Yes' or 'No'

1. Will the policy result in the processing of personal identifiable information / data? This includes information about living or deceased individuals, including their name, address postcode, email address, telephone number, payroll number etc.	No
2. Will the policy result in the processing of sensitive information / data? This includes for living or deceased individuals, including their physical health, mental health, sexuality, sexual orientation, religious belief, National Insurance No., political interest etc.	No
3. Will the policy involve the sharing of identifiers which are unique to an individual or household? e.g., Hospital Number, NHS Number, National Insurance Number, Payroll Number etc.	No
4. Will the policy result in the processing of pseudonymised information by organisations who have the key / ability to reidentify the information? Pseudonymised data - where all identifiers have been removed and replaced with alternative identifiers that do not identify any individual. Re-identification can only be achieved with knowledge of the re-identification key. Anonymised data - data where all identifiers have been removed and data left does not identify any patients. Re-identification is remotely possible, but very unlikely.	No
5. Will the policy result in organisations or people having access to information they do not currently have access to?	No
6. Will the policy result in an organisation using information it already holds or has access to, but for a different purpose?	No
7. Does the policy result in the use of technology which might be perceived as being privacy intruding? e.g., biometrics, facial recognition, CCTV, audio recording etc.	No
8. Will the policy result in decisions being made or action being taken against individuals in ways which could have a significant impact on them? Including profiling and automated decision making. (This is automated processing of personal data to evaluate certain things about an individual i.e., diagnosis and then making a decision solely by automated means - without any human involvement)	No
9. Will the policy result in the collection of additional information about individuals in addition to what is already collected / held?	No
10. Will the policy require individuals to be contacted in ways which they may not be aware of and may find intrusive? e.g., personal email, text message etc.	No