NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Working with People and Communities Committee

Date: Friday 16 December 2022
Time: 10am to 12noon
Venue: MS Teams

Agenda

No.	Agenda Item	Lead	Purpose	Proposed Time
Opening Actions				
1.	Welcome, Introductions and Apologies Appointments to vacancies on the committee: - VCSE - Health and Care Senate - Healthwatch Central Bedfordshire	Chair	-	
2.	Core Purposes of Integrated Care Systems: • **improve outcomes** in population health and healthcare • **tackle inequalities** in outcomes, experience and access • **enhance productivity** and value for money • help the NHS support broader **social economic development**	Chair		
3.	Relevant Persons Disclosure of Interests • Register of Interests	Chair	Note changes and approve	
4.	Approval of Minutes and Matters Arising			
5.	Review of Action Tracker • Resident Story & planning for January Board • Update from ICB Board on Working with People and Communities Strategy • VCSE MoU	Maria Wogan	Verbal Update	
6.	Agree key-items for discussion	Chair	Discussion	
7.	Engagement Forward View Update • Review of Working with People and Communities Policy	Sarah Frisby	Verbal Update	10:10

No.	Agenda Item	Lead	Purpose	Proposed Time
	• Update on the strategy and the engagement on the joint forward plan/operational plan • Reflections of engagement event with Trust NEDs on 30 November and Governors on 6 December 2022			
8.	Update on Denny Review	Michelle Summers	Verbal Update	10:20
9.	The BLMK Fuller Programme – Integrated Primary Care delivery	Amanda Flower	Discussion	10:25
10.	Musculoskeletal (MSK) Service redesign and procurement	Sarah Florey (TBC)	Discussion and note	10:45
11.	System-wide Co-Production training	Rachael Bickley	Note	11:00
12.	BLMK Integrated Strategy (draft)	Anne Brierley	Discussion and note	11:15
13.	Resident Voice on BLMK ICB committees	Maria Wogan/Rachael Bickley	Discussion to agree next steps	11:30
	Governance			
14.	Communications from the meeting	Chair	Discuss	11:40
15.	Review of meeting effectiveness a) What worked well / did you enjoy from today's meeting? b) What didn't work as well as expected or raised concerns with you?	Chair	Discuss	11:45
16.	Annual Cycle of Business (Next meeting Agenda items)	Chair	Discuss	11:50
	Closing Actions			
17.	Any Other Business	Chair	-	11:55
18.	Date and time of next meeting: ▪ Friday 17 March 2023 ▪ MS teams Deadline for papers will be: ▪ 3 March 2023	Chair	-	

Members are asked to:
> Review the Register of Interests and confirm their entry is accurate and up to date.

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

Extract from Register of Conflicts of Interest
Working with People & Communities Committee
as at 29.11.22

				Type of Interest								
Surname	**Forename**	**Position within, or relationship with the ICB**	**Interests to Declare**	**Financial Interest**	**Non-Financial Professional**	**Non-Financial Personal**	**Indirect**	**Description of Interest**	**Date From**	**Date To**	**Actions to be taken to mitigate risk**	**Date Declared**
Brierley	Anne	ICB Chief Transformation Officer	Yes				Y	My wife (Honey Lucas) has accepted a post in the MKUH charity team, with expected start date of January 2023	Jan-23	N/A	Declare in line with conflicts of interest policy	15/11/2022
Church	Laura	Chief Executive, Bedford Borough Council	Yes	Y				Bedford Borough Council, Commissioner of Public Health and Social Care Functions	05/10/2021	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
Church	Laura	Chief Executive, Bedford Borough Council	Yes		Y			East of England Local Government Association - Chief Executive lead on health inequalities	01/12/2021	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
Church	Laura	Chief Executive, Bedford Borough Council	Yes				Y	Ian Turner (husband) provides consultancy services to businesses providing weighing and measuring equipment to the NHS	05/10/2021	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
Gill	Manjeet	Non Executive Member	Yes		Y			Non Executive Director, Sherwood Forest Hospitals FT	11/11/2019	Ongoing	Would flag any conflict in agendas	27/09/2022
Gill	Manjeet	Non Executive Member	Yes		Y			Managing Director, Chameleon Commercial Services Ltd, 12 St Johns Rd, LE2 2BL	09/09/2017	Ongoing	Reglar 1-1s flag any issue and agenda items	27/09/2022
Graves	Stuart Ross	Chief Strategy & Digital Officer, CNWL NHS Foundation Trust	Yes		Y			Chief Strategy & Digital Officer CNWL NHS Foundation Trust, 350 Euston Road, London NW1 3AX	May-20	Ongoing	Declare in line with COI policy	15/11/2022
Mattis	Lorraine	Associate Non Executive Member	Yes	Y				Director - Community Dental Services CIC	Nov-19	Ongoing	Declared in line with conflicts of interest policy	09/09/2022
Nicholson	Lucy	Chief Executive, Healthwatch Luton	No									05/10/2022

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Shah	Mahesh	Partner Member	Yes	Y				AP Sampson Ltd t/a The Mall Pharmacy, Unit 3, 46-48 George Street, Luton LU1 2AZ, co no 00435961, community pharmacy	Nov-88	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes				Y	RightPharm Ltd, 60a Station Road, North Harrow, HA2 7SL, co no 08552235, community pharcy, son & sisters	28/03/2014	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes				Y	Calverton Pharmacy Ltd, 62 Calverton Rd, Luton LU3 2SZ, co no 07203442, community pharmacy, son & sisters	03/04/2018	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes				Y	Gamlingay Pharmacy Ltd, 60a Sation road, North Harrow, HA2 7SL, no no 05467439, son & sisters	01/04/2021	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes		Y			Committee Member, Bedfordshire Local Pharmaceutical Committee	1984	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes		Y			Community Pharmacy PCN Lead, Oasis PCN, Luton	06/02/2020	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Taffetani	Maxine	Healthwatch Representative for Bedfordshire, Luton and Milton Keynes	No									22/06/2022

				Type of Interest								
Surname	**Forename**	**Position within, or relationship with the ICB**	**Interests to Declare**	**Financial Interest**	**Non-Financial Professional**	**Non-Financial Personal**	**Indirect**	**Description of Interest**	**Date From**	**Date To**	**Actions to be taken to mitigate risk**	**Date Declared**
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes	Y				I am a Non-Executive Director and Deputy Chair of Northamptonshire Healthcare NHS Foundation Trust, St Mary's Hospital, London Road, Kettering NN15 7PW. NHFT provide prison health services to Yarlswood Immigration Removal Centre and Bedford Prison in BLMK. These services are not commissioned by BLMK ICB.	Nov-18	Ongoing	Exclusion from involvement in related meeting or d	14/07/2022
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes	Y				I am Chair of Trustees for Arts for Health MK a registered charity that is responsible for the art collection at MK University Hospital NHS Trust and provides art on prescription for MK residents. Address MK University Hospital, Standing Way, Eaglestone, Milton Keynes MK6 5LD	2010	30/09/2022	Will be declared as relevant in meetings and will not be involved in any funding or other decisions where Arts for Health MK may be a beneficiary. Standing down from role by 30/09/22.	14/07/2022
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes			Y		I am a member of Inspiring Futures Through Learning Multi-Academy Trust which covers schools in MK and Northamptonshire. Address: Fairfields Primary School, Apollo Avenues, Fairfields, Milton Keynes MK11 4BA	2016	Ongoing	Will be declared in any relevant meetings.	14/07/2022
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes	Y				I am a Director of Netherby Network Limited which is a consultancy company that has provided services to MK CCG in the past. It does not currently provide any services for health or care clients. Address: 69 Midland Road, Olney, MK46 4BP	Mar-14	Ongoing	No actions required as the company is not trading.	14/07/2022
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes				Y	Daughter, Eilis Humberstone, registered on the CNWL staff bank	11/07/2022	Ongoing	No further action required. My daughter holds a temporary admin role for summer 2022	14/07/2022

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 7th October 2022

Time: 10 – 12 am

Venue: MS Teams

Minutes of the: Working with People and Communities Committee (WWPAC)

Members (Voting):		
Name	*Role*	*Initial*
Manjeet Gill	Non Executive Member, Chair	MG
Laura Church	Chief Executive, Bedford Borough Council	LC
Lorraine Mattis	Associate Non Executive Member, Deputy Chair	LM
Lucy Nicholson	Chief Executive, Healthwatch, Luton	LN
Mahesh Shah	ICB Primary Medical Services	MS
Maxine Taffetani	Chief Executive, Healthwatch Milton Keynes	MT
Maria Wogan	ICB Chief of System Assurance and Corporate Services	MW

In attendance:		
Name	*Role*	*Initial*
Anne Brierley	Chief Transformation Officer	ABr
Michelle Evans-Riches	ICS Programme Manager	ME-R
Sarah Frisby	ICB Head of System Engagement	SF
Anona Hoyle	ICB Senior Engagement Officer	AH
Jane Meggitt	Director of Communications and Engagement	JM
Michelle Summers	Associate Director, Communications & Engagement	MSu
Hilary Tovey	Interim Director of Strategy & Planning	HT
Kim Atkin	Secretariat (Minutes)	KA

Apologies:		
Ross Graves	Chief Strategy & Digital Officer, Central & North West London Foundation Trust	RG
Karen Ironside	Transitions UK - VCSE	KI

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The new Chair, Manjeet Gill, welcomed everyone to this meeting of the Working with People and Communities Committee (WWPAC) and apologies were noted as above. The Chair thanked Alison Borrett for Chairing the Committee previously. Everyone introduced themselves and new members and attendees were welcomed. The meeting was confirmed to be **quorate**.	
2.	**Relevant Persons Disclosure of Interests** Members were asked to declare any relevant interest relating to matters on the agenda. There were **none declared.** LM **declared** her substantive role with community dental services and the fact that the organisation has had some involvement in the BLMK VCSE Strategy Group which was involved with the VCSE MoU. This was noted but there was not considered to be a conflict with the discussions. It was **noted** that attendees were asked to confirm that any offers of gift or hospitality received in the last 28 days, in relation to ICB business, have been registered with the Governance & Compliance Team. **No submissions had been made.**	
3.	**Approval of Minutes and Matters Arising** The draft minutes of the meeting held on 21 July 2022 were **approved** as a full and accurate record of the meeting.	
4	**Review of Action Tracker** All 6 items on the action tracker are proposed to close and it was **agreed** to close these.	
5	**Revised Terms of Reference** The Board **noted** that the revised Terms of Reference were approved at the meeting of the Board on 30 September 2022. MS queried whether Healthwatch, which now has four voting members on the Committee, has disproportionate representation on this Committee. MW confirmed that this had been discussed at the first meeting and that, as it is usual to make decisions by consensus and unusual to take a vote, this was not considered to be a concern. It was agreed that all four Healthwatch representatives were valuable on this Committee, but MT suggested that the "voting" part may need review, as it affects quoracy. MT also flagged that, at another meeting, concern had been expressed at the lack of experts by experience on the Board, which might also need to be	

	considered. **Action**: Committee to keep under review and address if it becomes an issue.	**Action 7: MW**
6	**Resident Stories** There had been a short discussion at the ICB Board meeting as to how to bring the residents' voice into meetings and how to hear that voice. Views were sought from the members as to the best way to bring those stories into Board and committee meetings. As well as thinking about system working and integration, we must also consider inequalities, the growth agenda and our responsibilities to improve outcomes for our population: - There needs to be an outcome from the story, not just the individual experience. - There needs to be a forward plan with a range of resident stories across different subject areas. - We need to work through the problems as well as celebrate what works well. - If the ICB members were to receive stories in advance of the meeting, they would be able to look at the story from their area/workstream's perspective, consider potential gaps, and bring that to the Board discussion. - Sometimes a good patient experience may include some less than perfect actions, for example, the patient attending a GP Practice where the individual needed was not available, but a colleague helpfully copied the patient's ID documents to save the patient having to return. - Need to understand what we are trying to get from these stories – need clarity on the purpose of bringing these stories to the Board. - Elected members are often aware of residents' views, how they feel and what they are asking for. - How do we get assurances that patient stories are inclusive. - Residents usually know the solution so it's about co-production – possibly even having a resident on one of the Committees. It was agreed that we need to be clear on the purpose at a system level, that we need to be reflect of diversity in terms of our approach and that the role of elective members as an advocate, and of the voluntary sector is another valuable source. **Action**: MW and colleagues to work with Healthwatch to identify stories based on the framework discussed and build a forward plan for Resident Stories.	**ACTION 8 MW/MSu**
7	**Working with People and Communities Strategy and Implementation Plan** The paper was taken as read and MSu summarised some of the key points: The document is a culmination of ten months of engagement work with partners across the system, so that it can be aligned to the strategies that already exist and	

	build on best practice and some of the good working practices established during the pandemic. NHSE published a guide last year which sets out 10 new priorities for working with people and communities, from which we were asked to develop a plan for our area. The principles focus on using trusted voices in the community and co-production. It is important to have a continuous conversation with residents where we inform, listen, discuss, collaborate, and empower our local communities to get involved in their health and care. The findings of a four-month engagement exercise at the beginning of the year is included in the Appendix to the document, and further engagement has been undertaken with Councils, Healthwatch and the voluntary sector. A new chapter of co-production is being developed, led by East London Foundation Trust, Cambridgeshire Community Services and BLMK Mind, which will be included in this document, together with new case studies, which will be taken to the ICB for final approval in November. The focus of the strategy is how we can act on insight and make sure it is locally focused and meaningful to the residents. We have learned through the pandemic that people have trust issues and look to local leaders for support, so we need to capitalise on the good work during the pandemic. We are working with local people better to understand how to break down barriers and ensure full transparency through our communications. We are already in a good place regarding governance as we are one of only a few ICBs who have a policy for this area. An insights bank is in the plan to build on population health data and identify trends for further focus. It is planned to roll out a system agreed development programme to support commissioners and resident facing officers in understanding their legal duties. Feedback on the proposals was given: - We must fulfil our statutory duties and move to a more co-production model. - Ward councillors have a clear understanding, knowledge base and responsibility in their own areas, and we need to make use of that and be clear on their role in the strategy. - Foundation Trust governors also need to included in this work. - At Primary Care level, there is a lot of interaction and feedback from residents – is there a platform for residents and health and care professionals to feedback, perhaps digitally? - Insight bank needs further development and discussion by the committee. - The strategy is good; however, it would be helpful to have a public facing summary or version. - There should also be a version for elected members, to understand their role and how they are going to be listened to.	

	- It is important that the different providers within the system know their responsibilities around, for example, patient surveys. - There is a real culture shift required, from silo working to a more bottom-up way of working. In the medium term, we will become more integrated, but the aim is for people to feel empowered to engage and do things themselves. - The staged approach that is being taken should be acknowledged – the system is now changing. - Start with the engagement we have already undertaken and the priorities that are emerging. - We must listen to the people in the supply chain and working on the front line e.g. what do the nurses think about the challenges they face? They probably have some of the answers. JM shared that we were commended by the region on the work that we have done so far. **ACTION:** MG to share the Ladder of Participation with the group. **ACTION:** MW and team to take on board feedback, update the strategy in the light of the comments and produce summary versions for residents and elected Councillors as part of the onward development work.	**ACTION 9 MG** **ACTION 10 MW/JM/Msu**
8	**VCSE and BLMK ICB Memorandum of Understanding (MOU)** The draft MOU between the ICB and VCSE was brought to this committee for comment. It is intended to set out our commitment to VCSE and ensuring that the sector is integral in our work as an ICB. The voluntary sector is very keen to have this commitment and is looking to work collaboratively as a strategic partner. Feedback from the Committee was received: - The paper sets out the relationship well, and about how the ICB leadership has oversight of how neighbourhood health is evolving. - There is a lot of collaboration between VCSE and Healthwatch but less interaction and engagement at ICB level. - The voluntary sector is used to competition for funding and is used to collaborating in this space, but we need to be careful of our messaging in this area. The VCSE is focussed on output and outcomes, and our work should encourage collaboration but acknowledge that there will be a context of competition for funding. - The need for resources to support VCSE engagement for this activity should not be underestimated; and - Need to think about leverage within the system and the different types of funding that are available outside the NHS, such as lottery funding. **ACTION:** MW/MER to reflect the Committee's views in the further development of the	**ACTION 11:**

	MoU before it is presented to Board for approval.	**MW/MER**
9	**Engagement Plan for Integrated Care System (ICS) Strategy** The Integrated Health and Care Strategy is being developed by building on the information we already have e.g., Health and Wellbeing strategies, Place plans, population health data. These insight sources have helped in identifying key themes like inequalities, personalisation, integrated working and a focus on prevention. The guidance is not prescriptive, and it is proposed to publish an outline strategy in December 2022 and continue to evolve and develop it through 2023/24. The wider engagement of the strategy will be undertaken in the new year with the emerging Joint Forward Plan which the ICB is required to publish by the end of March 2023. The forward plan will define the actions to be taken in the next 5 years to realise the outcomes in the integrated health and care strategy. We will continue to work with the engagement collaborative to address the engagement gaps and linking it to emerging information e.g. the outcomes of the Denny review. Feedback from the Committee was received: - Support building on the insight that the system already had and avoid engagement fatigue. - Involvement of residents and identifying what their role is in delivering the outcomes. The Wigan Deal was given as an example. Having a small number of promises and pledges that are easily recognised and remembered. - Locally elected Councillors, Healthwatch and community groups have valuable insight into the needs and views of local people and neighbourhoods. - The strategy is not a refresh of the long-term plan, but a fundamental shift to looking at this from the perspective of the resident and community. There is a need to identify and commit to doing things differently. The ICB plan should identify a small number of key issues that will be addressed collectively with the focus of change at Place. - The subsequent change will not just be measured in terms of outcome, but also the residents experience and views. Views of the stakeholders in the supply chain and workforce are also important. - It was clarified that the Health and Care Partnership is a joint Committee between the ICB and five local authorities in BLMK and is responsible for developing the Integrated Health and Care Strategy. The ICB is providing resources to support the Partnership and the development of the strategy and is responsible for the subsequent plan to deliver the strategy. It also has the responsibility for delegating resources to Place and alliances to deliver the plan locally. The WWPAC Committee were being asked to advise on the engagement process of the strategy but as a Committee of the ICB do not have the authority over the way in which the strategy is being developed beyond being one of the founding members of the BLMK Health and Care Partnership. The ICB does have authority over and responsibility for the production of the Joint Forward Plan and engagement plans for that work. - Development of the strategy and the plan concurrently means that we are building on what we already know for the publication of the strategy in	

	December and it will iteratively continue to be developed. It is important to keep momentum. **ACTION**: That Tracey Stock, as Chair of the Health and Care Partnership be invited to future meetings when engagement of the Integrated Care Strategy is being considered. **ACTION:** That the Committee Terms of Reference are reviewed to ensure clarity regarding its role in providing advice to the ICB and other Committees on communications and engagement.	**ACTION12 AH** **ACTION 13 AH/MW**
10	**Denny Review** The Denny Review was commissioned to undertake a health inequalities review in BLMK. It focused on gaining an understanding of which communities experience the greatest inequalities in our area, what the barriers are, what the lived experiences of health inequalities are and more importantly what are we going to do about it. It started from a call from the Windrush descendants in Bedford Borough who demanded action on health inequalities and we have been working with them to make improvements, particularly regarding vaccination roll out. It was decided to undertake a wider review of health inequalities and Reverend Lloyd Denny was commissioned to undertake the work. Public Health, Healthwatch, University of Bedfordshire and system partners have taken an active role in the review. This work is tied into the Inequalities workstream. The Denny Review steering group commissioned a literature review of inequalities in BLMK which was undertaken by the University of Sheffield. It highlighted that people from the following communities experienced the greatest health inequalities: - Gypsy, Roma, Travellers - People living in deprived neighbourhoods - People living in deprived neighbourhoods with disabilities, physical or learning disabilities - People experiencing homelessness - Migrants - People from the LGBTQ+ community There are multi factorial issues that contribute to the health inequalities. The literature review identified the following recommendations: - Maximise the accessible services for disadvantaged groups - Listen to the homeless - Targeting community communications - Ensuring VCSE support - Cultural competency, i.e. the culture of the health and care organisations which is often a barrier to those experiencing health inequalities and also a barrier to good health. Another recommendation was not to homogenise people as their experiences are individual and are different. We have been discussing this with partners and a number of engagement schemes have been initiated with field work underway. • Bedford Borough Healthwatch and partners are working with people from	

	ethnic minorities who live in a deprived area and experience domestic violence, forces marriage or FGM • Bedford Borough Healthwatch is working with the settled Irish traveller community, • Healthwatch Central Bedfordshire and the Disability Resource Centre are working with people with learning or physical disability in Central Bedfordshire and Luton. • Healthwatch Luton are working with people from ethnic minority community who are LGBTIQ+. • The ICB team are working with the Roma community, who through the literature review have been highlighted as experiencing the greatest health inequalities in BLMK. • Healthwatch Milton Keynes, YMCA and Community Action MK people in deprived communities in Milton Keynes, Other proposals are awaited regarding homelessness in Milton Keynes and sex workers in Central Bedfordshire. A report on the field work being undertaken will be reported to the Denny Review Steering Group in January 2023. Work needs to be undertaken with stakeholders regarding culture and language which can be a barrier to accessing health care. Sensitivity training will be undertaken with individual organisations e.g. GP practices. Feedback from the Committee was received: - It would be helpful to have more demographic information on the size of the problem. - The Denny review engagement programme is designed to highlight the views and voices of those in our community that are not usually heard and to obtain a response from the system on how to manage the different needs. **ACTION:** MSu to share the population health information used as part of the review. . **Agreed: That the following be noted:** 1) **Purpose of the Denny Review** **2) The methodology and focus of the engagement with local communities** **3) The workstreams set out in the paper.**	**ACTION 14 MSu**
11	**Winter Plan** The following points were made on the winter communications plan: - Welcomed the oversight of the communications plan and it was emphasised that the delivery of communications to residents and segmentation was key. - Implications on mental and physical health for people being on waiting lists for a long time, whether this has been assessed and how communications can help in supporting people on waiting lists. **Agreed**: That the winter communications plan be noted and supported.	**ACTION 15: MSU**
12	**Statutory Engagement – service changes**	

	ACTION: Local authorities often had voluntary sector compacts on engagement and the details of the existing compacts in BLMK will be obtained. It was clarified that the statutory requirement to engage and consult on health services had transferred from BLMK CCG to the ICB on its establishment on 1 July 2022. This needs to be aligned to partner responsibilities on engagement and whether there are any opportunities to combine engagement and consultation. The document needs to reflect the different categories of engagement. **Agreed**: that the statutory engagement plan be noted and supported.	**ACTION 16 SF** **ACTION 17 SF**
13	**Working with People and Communities Committee sub-group – System-wide Engagement Collaborative** The paper was taken as read and members' views on whether the Engagement Collaborative should be a sub-group of this Committee. There was a short discussion and it was **agreed** that the Engagement Community of Practice be established but that it should sit as a community of practice, not as a subgroup of WWPAC.	
14	**Communications from the Meeting** It was **agreed** to share the following points for wider communication to the system: - The discussion around the Committee's role and aligning it with the ICB; - The engagement for the strategies and ensuring that the strategies are "our" strategies, not just responses to national requirements; - How the working with people and communities and integrated health and care strategies can be published in an accessible way to the public; - Helpful feedback on the VCSE MOU.	
15	**Review of Meeting Effectiveness** **Feedback from the members was taken:** - MS – Well Chaired, pleased that more time was given to discussions than reporting – although time restrictions are always a problem; - MW – Papers need to be taken as read, with a short verbal introduction at the meeting, to allow more time for further discussion; - LC – Welcome that the pack was main papers without too many supportive documents; - LC - Agenda management – maybe too many items for discussion with	

	insufficient time; MG undertook to ask at the beginning of each item which are the key items for discussion or members and manage the time accordingly. - JM – Taking into account that some members have been involved with some of the issues for some time, it might be helpful to highlight to the committee the big strategic pieces of work. **Action:** MG – At beginning of meetings, to agree key items for discussion and manage time accordingly.	**ACTIION18: AH for agenda**
16	**Annual Cycle of Business (next meeting agenda items)** The Annual Cycle of Business was shared for information and will be revised in light of discussions at the meeting and the engagement plan. **ACTION:** AH to update the annual cycle of business.	**ACTION 19 AH**
17	**Any Other Business** There was none.	
18	**Date and time of next meeting** • 16 December 2022 • MS Teams Deadline for papers will be noon on 2 December 2022 The meeting closed at 11.53	

Approval of Draft Minutes:		
Name	Role	Date
Manjeet Gill	Chair	21/10/2022

Working with People and Communities Action Tracker

Key

Escalated	**Escalated** - items flagged RED for 3 subsequent meetings - BLACK
Outstanding	**Outstanding** - no actions made to progress OR actions made but not on track to deliver due date - RED
In Progress	**In Progress.** Outstanding - actions made to progress & on track to deliver due date - AMBER
Not Yet Due	Not Yet Due - BLUE
COMPLETE: Propose closure at next meeting (insert date of meeting)	**COMPLETE** - GREEN
CLOSED (dd/mm/yyyy)	Actions to be marked closed and moved to 'Closed Actions" Tab once approved for closure at meeting.

Action No.	Meeting Date	Agenda Item	Action	Action Owner	Past deadlines (Since Revised)	Current Deadline	Current Position (Latest Update)	RAG
7	07/10/2022	5	Committee to keep revised ToR under review and address if it becomes an issue (voting rights, quoracy and membership)	MW		31/03/2023		**Not Yet Due**
8	07/10/2022	6	MW and colleagues to work with Healthwatch to identify resident stories based on the framework discussed (outcome from story and build a forward plan for Resident Stories.	MSu		16/12/2022	Working with Healthwatch and others partners to bring stories which demonstrate the benefits we bring to residents.	**COMPLETE Propose closure 16.12.22**
9	07/10/2022	7	MG to share the Ladder of Participation with the group.	MG		16/12/2022	Information available on this link https://www.participatorymethods.org/method/levels-participation	**COMPLETE Propose closure 16.12.22**
10	07/10/2022	10	Take on board feedback, update the strategy in the light of the comments and produce summary versions for residents and elected Councillors as part of the onward development work.	MSu		16/12/2022	Stategy was updated and was presented to Board on 25 November. The Board have requested some refinements before they provide final approval. MW to provide verbal update on 16/12/22	**COMPLETE Propose closure 16.12.22**
11	07/10/2022	8	MW/MER to reflect the Committee's views in the further development of the MoU before it is presented to Board for approval.	MW / MER		16/12/2022	The VCSE MOU was updated following the comments from the WWPAC Commtitee and approved at the ICB Board on Friday 25 November 2022.	**COMPLETE Propose closure 16.12.22**
12	07/10/2022	9	Invite appropriate system partners to future meetings - i.e. Tracey Stock, as Chair of the Health and Care Partnership to future meetings when engagement of the Integrated Care Strategy is being considered.	AH		16/12/2022	Noted and will invite system partners as appropriate	**COMPLETE Propose closure 16.12.22**
13	07/10/2022	9	That the Committee Terms of Reference are reviewed to ensure clarity regarding its role in providing advice to the ICB and other Committees on communications and engagement.	AH / MW		16/12/2022	The ToR have been reviewed and provide clarity	**COMPLETE Propose closure 16.12.22**
14	07/10/2022	10	MSu to share the population health information used as part of the review.	MSu		16/12/2022	Distributed at the same time as meeting packs	**COMPLETE Propose closure 16.12.22**
15	07/10/2022	11	Reflect committees views on the winter communications plan	MSu		16/12/2022	The feedback was included in the final plan	**COMPLETE Propose closure 16.12.22**
16	07/10/2022	12	Find out whether the local authorities or the former CCGs have existing voluntary sector MoUs or compacts on engagement.	SF		16/12/2022	The Bedfordshire and Luton Compact was published in 2011. Public sector signatories include the three LAs, Bedfordshire PCT, L&D Hospital, Beds &Luton Fire and Rescue service Information regarding Milton Keynes still required	**In Progress**
17	07/10/2022	13	Update the forward plan for engagement to reflect the different categories of engagement	SF		16/12/2022	Update included on agenda (agenda item 6)	**COMPLETE Propose closure 16.12.22**

Action No.	Meeting Date	Agenda Item	Action	Action Owner	Past deadlines (Since Revised)	Current Deadline	Current Position (Latest Update)	RAG
18	07/10/2022	15	Update future meeting agendas to include discussion at start of meeting to agree key items for discussion, so the time in meetings can be managed accordingly.	AH		16/12/2022	Agenda template updated	**COMPLETE Propose closure 16.12.22**
19	07/10/2022	16	Update the annual cycle cycle of business	AH		16/12/2022	Updated and included on agenda	**COMPLETE Propose closure 16.12.22**

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Working with People and Communities Committee
9 – The BLMK Fuller Programme – Integrated Primary Care delivery

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

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

Report Author	Amanda Flower – Associate Director Primary Care Commissioning & Transformation Steve Gutteridge - Senior Primary Care Transformation and Commissioning Programme Manager
Date to which the information this report is based on was accurate	02/12/22
Senior Responsible Owner	Nicky Poulain – Chief Primary Care Officer

The following individuals were consulted and involved in the development of this report:
BLMK Clinical Leads for Access Engagement with the four place boards is in progress and ongoing. BLMK PCN Clinical Directors. BLMK Access Stakeholder Group.
This report has been presented to the following board/committee/group:
ICB Primary Care Delivery Group – 08/11/22 BLMK PCN Clinical Directors Meeting – 22/11/22 BLMK Primary Care Forum – 30/11/22 BLMK ICB Board – 25/11/22
Purpose of this report - what are members being asked to do?
The members are asked to **note** and **discuss** the following: A) The establishment of the BLMK Fuller Programme and the vision for Integrated Primary Care in BLMK. B) Support coproduction and public engagement in the development of the BLMK Fuller Programme with an initial focus on primary care access.

Executive Summary Report

1. Brief background / introduction:

The BLMK Fuller Programme is a system programme with the aim of anchoring transformation and ultimately integrated primary care around our neighbourhoods. The BLMK programme will utilise the 'Place Boards' to steer and implement the recommendations of the Fuller report that are sensitive to local population need (see link in Background Reading).

The programme is being developed by the ICB Primary Care Team with the support from the ICB Prorgamme Management Office Team. The BLMK Fuller Programme is framed using the following 4 pillars:
1. The development of neighbourhood teams aligned to local communities.
2. The provision of streamlined and flexible access for people who require same day urgent care.
3. The provision of proactive personalised care and support for people with complex needs and co-morbidities.
4. An ambitious and joined up approach to prevention.

The BLMK Fuller Programme is accountable to the Primary Care Commissioning and Assurance Committee and will also be overseen by the ICB Fuller Programme Working Group and the BLMK Fuller Stakeholder Collaborative Group. See Appendix A – BLMK Fuller Programme Connectivity & Collaboration.

2. Summary of key points:

Collaborative approach to developing the vision for integrated primary care, to be delivered at neighbourhood and place, facilitate by the BLMK Fuller Programme.

This paper is to seek support from the Working with People and Communities Committee as we develop the programme to deliver integrated primary care. The initial priority is better communication to our residents and patients about range of available primary care services to meet local need.

3. Are there any options?

These will be identified during the development of local implementation plans.

4. Key Risks and Issues

These will be identified through implementation.

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

Not specifically to this programme but to related items such as demand and access.

5. Are there any financial implications or other resourcing implications, including workforce?

These will be identified during the development of the local implementation plans.

6. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan
The implementation will work on digital first where appropriate and any estates will be built in line with the Green Plan.
7. How will / does this work help to address inequalities?
Implementation will provide continuity of care for those in Core20plus5.
8. Next steps:
To continue to develop the BLMK Fuller Programme Plan. To build a plan for co-production and population engagement.
9. Appendices Appendix A – BLMK Fuller Programme Connectivity and Collaboration Appendix B – Sample of Place Based Communications

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Integrated Care Board

BLMK Fuller Programme

1. Background

Following the publication in May 2022 of 'Next steps for integrating primary care: Fuller stocktake report' we are collaboratively building our vision for Integrated Primary Care and the Programme Plan for implementation in BLMK.

To support the development of 'Place and Neighbourhoods the BLMK Fuller Programme is being collaboratively designed with system partners, using expertise from the ICB PMO Team, to capture and align the core primary care transformation priorities with the wider system transformation schemes.

Socialising the 'Fuller' report's recommendations has taken place across our system with stakeholders exploring how the recommendations should be applied at system, place, and neighbourhood.

We are seeking support and guidance from the Working with People and Communities Committee to build our approach to working with our population as we develop this programme.

2. Scope

Our BLMK Fuller Programme is constructed using 4 pillars:

2.1. The development of neighbourhood teams aligned to local communities

2.2. The provision of streamlined and flexible access for people who require same day urgent care

2.3. The provision of proactive personalised care and support for people with complex needs and co-morbidities

2.4. An ambitious and joined up approach to prevention.

2.1. The development of neighbourhood teams aligned to local communities

The Place Boards are pivotal to developing neighbourhood teams as they provide a central point for collaborative planning and mobilising integrated care; keeping the voice of our residents and patients central to everything we do. Building 'teams of teams', sometimes virtually, around primary care network (PCN) populations or cohorts of people with similar needs retaining a focus to address inequalities is our goal. Prior to and at pace during the pandemic 'virtual' teams have evolved consisting of Voluntary, Community and Social Enterprise (VCSE), and health and care providers. From these developments we have a fantastic opportunity to learn and share and develop.

Examples of embryonic and developing neighbourhood teams include working together to ensure there are 'warm spaces' for residents most affected by fuel poverty; the integrated approach at 'The Lakes Estate in Milton Keynes'; 'Place Based Vaccines in Luton', 'Working Together' in Leighton Buzzard; and the Bedford Primary Care Hub programme.

The ongoing development of neighbourhood teams will include all parts of the health and care and VCSE system in BLMK.

We want to understand what is currently working well for our population and what is working less well; we want to know what our population understand about general practice and primary care and what is important to our population about the primary care offer they receive.

2.2. The provision of streamlined and flexible access for people who require same day urgent care

The 'Same Day Urgent Primary Care' (incorporating our Access Programme) pillar of Fuller is well established and developed and has the benefit of dedicated clinical leadership.

It is evident that access to same day (urgent) care has changed during the pandemic and is continuing to change. 93 practices in BLMK manage flow according to the capability of their infrastructure and their individual capacity. Consequently, this variation impacts the utilisation of 111 and the integrated urgent care offer (clinical assessment service and out of hours service) and activity in Urgent Treatment Centres/Walk In Centres, Urgent GP Clinics, 111 and A&E is unpredictable.

In October 2022:

- There were 509,343 appointments provided by practices in BLMK
- There is a range of appts per 1,000 pop from 241.06 to 839.65
- On average 78.4% of these appointments were provided face to face (the range was from 15% to 97%
- On average 37.8% of appointments are on the day appointments (the range is from 17.6% to 69.6%) – however we don't truly know what the 'urgent' demand is and this makes modelling and designing the future model challenging.

In November we launched our 'GP Access communication campaign' across the BLMK system to explain what primary care is and how it is operating with an embedded data driven approach to help our communities understand the true picture. Clinical leadership has been central to this campaign. Appendix B provides a 'sample' (Central Bedfordshire).

On Thursday 24th November the Government launched GP Access Data to the public. This data provides by practice the total number of appointments, the number of same day appointments, the number of appointments face to face and the number of appointments provided by GPs (%'s are also utilised). Our own dashboard is being reviewed and developed given this recent national development.

Discussions have been held, and are ongoing, with PCN Clinical Directors and Primary Care Clinical Leaders and Providers to support the identification of the right approach to a scaled model to provide same day care for the population when they require urgent episodic access.

We are working closely with our practices, PCNs, the Local Medical Committee, Local Authority colleagues and Healthwatch to understand the challenges in accessing primary care.

We need to understand what matters to our population when accessing urgent care. What do our population understand about the difference between routine, urgent and emergency care? When does it matter the most to our population to get same day access to primary care? What matters the most about access to primary care for our population?

2.3. The provision of proactive personalised care and support for people with complex needs and co-morbidities

Providing the population who are at risk of adverse health outcomes with a named clinician to coordinate the continuity of care they need is quite well developed in parts of BLMK. The developments have focused on those living with Long Term Conditions (including children with neurological conditions), and/or those living with Frailty, those living with and after Cancer, and those known to be in the last 12 months of their life.

As an initial priority we propose to fully map the plethora of current initiatives in the system relating to 'complex care', including a review of their purpose and an assessment of impact on patient experience and outcomes.

We want to her from our population with long term conditions, and multi morbidities to understand what is good about their care and support now and what could be better? We want to know what matters most to them?

2.4. An ambitious and joined up approach to prevention

Primary Care including Primary Medical Services (GPs), Community Pharmacy, Dental and Ophthalmology all have an essential role to play in preventing ill health (through a Making Every Contact Count approach) and tackling health inequalities.

We know that the preventative offer to our population is variable in how it is taken up and we need to understand what matters to our population the most and what are their barriers in accessing the preventative offer.

We think Covid and flu vaccinations, an all-age immunisation workstream, cancer screening, health screening, case finding long term conditions, the tobacco dependency programme, weight management and focusing on inequalities at a PCN level are really important. Do our population think these things are also important and how can we improve their understanding and engagement of their evidence and impact?

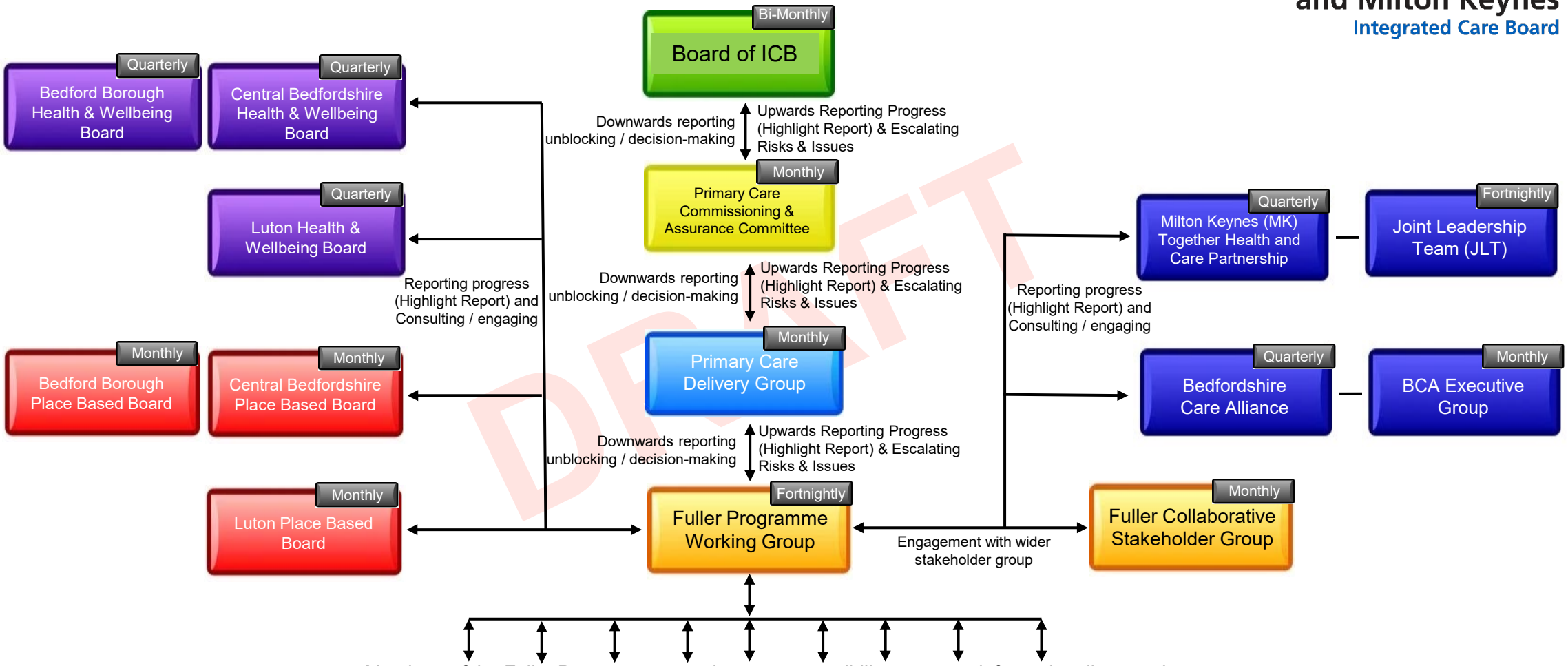
3. Next Steps

In order to be able to deliver the BLMK Fuller programme, we need to continue conversations with our residents, our current primary care providers and all system stakeholders regarding how integrated primary care – with an initial focus on access - can be delivered moving forward. It is imperative that we hear what is currently working, what is not working so well – and how we can be transformational in our approach.

BLMK Fuller Programme – Collaboration & Connectivity

Item 6 Appendix A

Bedfordshire, Luton and Milton Keynes Integrated Care Board



Members of the Fuller Programme team have a responsibility to ensure information discussed within the team is appropriately disseminated to interested or influential stakeholders/groups. Equally members also have a duty to feed information back into the Fuller Programme Team from any interested or influential stakeholders/groups, for example the Primary Care Access Group

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Primary Care Access Bulletin: Central Bedfordshire

November 2022

Welcome

Welcome to the first Primary Care Access bulletin, which aims to share current information about GP practices to staff and patients alike in each local area. Future editions will include any planned changes to help inform local people about what improvements are being made.

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

Primary Care Access Bulletin

Accessing your General Practice team

GP practices have remained open throughout the Covid-19 pandemic but have had to adapt to very different ways of working to ensure the safety of patients and staff. **Some of these new ways of working**, which include the **use of telephone and video calls**, are being retained as these are viewed as helpful by many local people and healthcare professionals. But **practices have also returned to seeing people face-to-face**, just as it was before the pandemic.

Working in this hybrid way allows practice teams to ensure we provide personalised care to our residents and ensure we can respond to rising demand for services.

This bulletin is designed to help you understand how you can access your local surgery team, the different methods you can use, and the different services you might need. Not every service and discipline is available in every practice – this bulletin is intended to be used as a guide alongside the information available locally from your practice and/or Primary Care Network.

Primary Care Access Bulletin

Can patients still see GPs face-to-face?

Face-to-face appointments with the practice teams in Central Bedfordshire remain a consistent method of consultation – where indicated by clinical need. Based on national figures, our practices collectively provide some of the highest percentage of face-to-face appointments across England.

Central Bedfordshire

Indicator	Activity – month of October 2022	Activity – month of October 2021
Total appointments offered by practices	161,440	157,169
Appointments that were with a professional other than a GP	56%	54%
% of total appointments that were face to face	85%	80%

Primary Care Access Bulletin

Can patients still see GPs face-to-face? *continued*

Importantly telephone or video consultation will continue to be offered as a clinically safe option where this is the right thing to do, as they reduce travel burden for patients and minimise risk of infections such as Covid-19 and flu being spread to other people. Face-to-face appointments with GPs and other clinical members of the practice team take place where there is an identified need. This may be clinical when a patient needs to be seen in person to assess their condition or non-clinical, for example a patient is unable to use a telephone or digital systems to speak with the practice.

Most practices will call all patients first and offer face-to-face appointments based on these discussions. This allows practice staff to triage patients based on clinical need, allowing clinicians to work more efficiently and increase capacity to support more people. Practice teams are asking their registered population to be patient with this 'new system' and to be assured that those needing to be seen in person will get offered a face-to-face appointment if and when needed.

What is total triage?

All surgeries altered their ways of working because of the pandemic to run a 'total triage' model or 'talk before you walk', enabling patients to be directed to the most appropriate service including:

- **telephone**
- **e-mail or video consultations**
- **referrals to external services**
- **or if clinically appropriate, a face-to-face appointment.**

Patients contacting their GP practice are asked to provide information to the practice reception team about the reasons for their contact.

Primary Care Access Bulletin

Why do reception staff ask such personal questions when I call?

We ask all patients to give reception staff as much information as they can, so they may be directed to the right person in a timely way.

Most of our GP surgeries operate a triage system, which is supported by a dedicated, trained team of individuals – including receptionists; who have received specific training to support triage. All reception staff, as part of the practice's triage system, work under a strict confidentiality contract.

The information patients give the receptionist allows the clinical team to make an informed decision on the most appropriate option to provide. This may be a call from a GP or other member of the practice team, or an appointment to visit the practice or another part of the health service, such as a pharmacy.

There are many different clinical staff that work in GP surgeries and the questions that the triage team ask helps to make sure you are directed to the most appropriate clinical staff member to assist you. All members of the practice team are highly trained, and practices now take a multidisciplinary approach to patient care to ensure people are seen by the right person at the right time. This may not always be a GP, and in many cases will not need to be. For example, pharmacists can deal with medication queries/repeat prescription issues and medication reviews just as effectively as a GP. This allows GPs to focus on clinical matters and unwell patients.

Primary Care Access Bulletin

Why am I offered appointments with clinical professionals other than my GP?

To respond to the increasing demand for health care services, the size and diversity of primary care team members has increased, and **additional practitioners have joined our primary care workforce**, including:

- **Nurse practitioners**
- **Pharmacists**
- **Mental health practitioners for adults and children**
- **Social prescribers and health coaches**
- **Paramedics**

In addition, primary care teams are working more closely with colleagues from local hospitals, the local authority, voluntary organisations, and community groups including sharing office space/facilities.

This approach ensures primary care teams can offer more rounded and holistic care and reduce ‘hand-overs’ to other agencies.

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Primary Care Access Bulletin

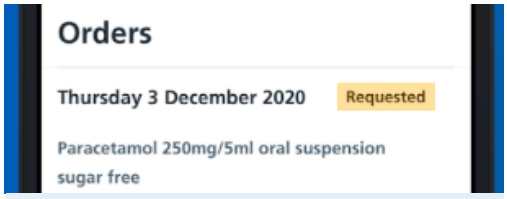
How can you help general practice?

Self-care or use pharmacy services as a first step when you feel unwell.

Be patient, be polite and be kind – our staff are working as hard as they can.

Did You Know:

Repeat prescription requests can be managed through their surgery website or via the NHS App.



Patients can also register for an online account with their practice to order medication, view their patient record or see test results using the practice website or NHS App.

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

What to do if you are unwell & need to be seen today for a non-emergency!

What to do if you are unwell

Need to be seen today for a non-emergency?

Think GP First

Call your GP practice between **8am - 6pm Monday - Friday**

NHS 111

Contact **NHS111 online** or **call NHS 111 between 6pm - 8am** and at the weekends if you have an urgent same day health need where you will be signposted to a service close to where you live.

Need to be seen today for an emergency?

Minor injury call NHS 111

Strains, cuts, sprains and burns can all be treated at our **Urgent Treatment Centres** at **Bedford Hospital**, Putnoe Walk-in Centre, Luton UTC at Town Centre GP Surgery or Milton Keynes UCC at Milton Keynes Hospital.

ED or Call 999

Call 999 straightaway for chest pains, choking, severe blood loss, blacking out, unconsciousness, suspected stroke or serious injury.

Alternatively you may be able to help yourself

Help Yourself

For hangovers, grazed knees, coughs and sore throats visit www.nhs.uk also download the free Child Health app.

Pharmacy

For diarrhoea, runny nose, painful cough and headaches visit your local pharmacy for free advice and to buy medication.

NHS 111 BSL service for Deaf patients www.interpreternow.co.uk/nhs111 **999 texting service for Deaf patients** - you **MUST** register first. Text 'Register' to 999 & follow instructions. In emergency text 'Ambulance' & address. Find out more at www.emergencysms.org.uk

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Integrated Care Board

Report to the Working with People and Communities Committee
10 – Musculoskeletal (MSK) Community Service Redesign and Procurement

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

Enablers			
Data and Digital ☒	Workforce ☒	Ways of working ☒	Estates ☒
Communications ☒	Finance ☒	Operational and Clinical Excellence ☒	Governance and Compliance ☒
Other ☐(please advise):	For a truly integrated Community MSK service all of the above need to be included.		

Report Author	Sarah Florey – Senior Commissioning Manager
Date to which the information this report is based on was accurate	29.11.22
Senior Responsible Owner	Tara Dear - Head of Planned Care

The following individuals were consulted and involved in the development of this report:
Sian Pither – Commissioning Manager Angela Reynolds – Commissioning Support Manager
This report has been presented to the following board/committee/group:

The MSK programme has been presented to the BLMK ICS System Strategy Group and BLMK Elective Collaboration Board, Bedfordshire Care Alliance Executives Group, BLMK Health and Care Senate and is overseen by the BLMK MSK Steering Group.

Purpose of this report - what are members being asked to do?

The members are asked to **note** / **discuss the** following:
A) Note for awareness the Community MSK scope and model is under review in advance of a formal procurement process for a new contract to commence April 2024, share initial feedback shaping the new scope/model
B) To support how patients and residents will be further involved during the procurement process and to provide assurance to the Board that patients are being engaged with

Executive Summary Report

The purpose of this paper is to provide the Working with People and Communities Committee with an update on the current review and redesign project for community musculoskeletal (MSK) provision within Bedfordshire, Luton and Milton Keynes (BLMK), whilst understanding the MSK needs at place. The timing of this review has initially been driven by the expiry of community MSK contracts on 31st March 2024, but provides a valuable opportunity to assess, evaluate and redesign the model of care for our residents. Approximately 80,000 residents are referred to Community MSK services each year.

Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB), alongside a wide range of BLMK stakeholders, have taken a comprehensive approach to understanding the current services – both what works well and what could be improved. In addition to stakeholder feedback, national best practice, performance reviews and an MSK Health Needs Assessment, BLMK ICB have also established an MSK Engagement Plan which sets out a plan to engage with key user and carer groups to capture their lived experience of MSK health problems, what they have experienced whilst on the MSK pathway and what are the areas they would like to see improved.

This report sets out the case for change for MSK, the proposal for engagement (including an update on engagement carried out to date) and a summary of next steps. The Working with People and Communities Committee is asked to note the content of the report and to provide support and approval of the MSK Engagement Plan.

1. Brief background / introduction:

Musculoskeletal (MSK) conditions are those affecting the bones, muscles and joints such as arthritis, frozen shoulder, fibromyalgia, chronic pain, plantar fasciitis, carpal tunnel syndrome, tennis elbow, slipped disc, sciatica, rheumatoid arthritis, ankylosing spondylitis.

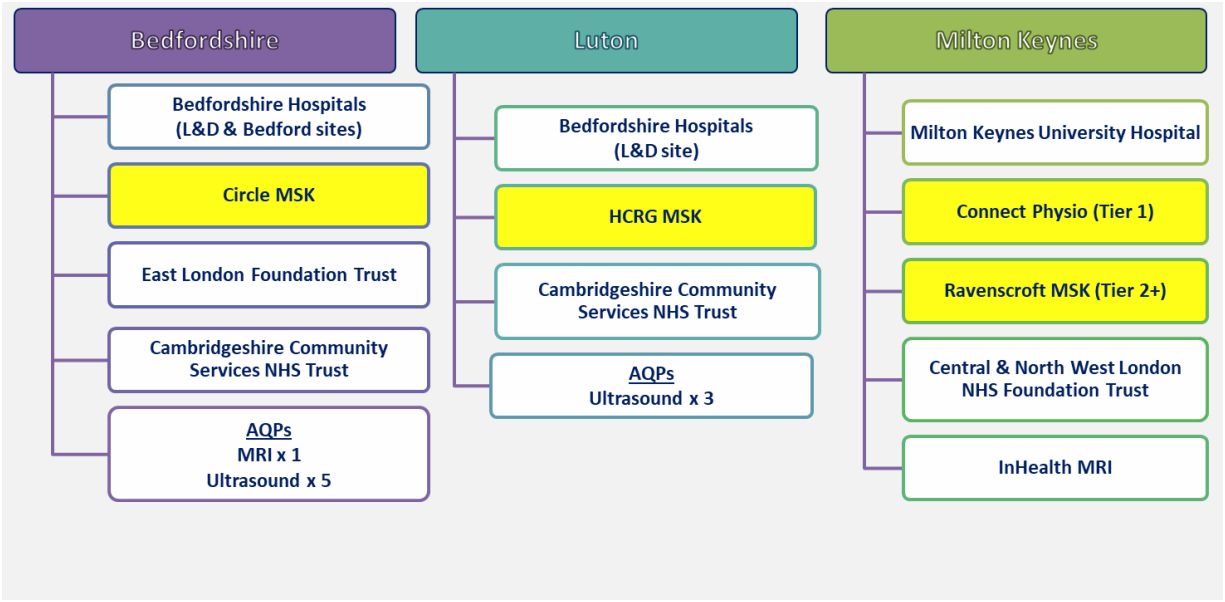
As highlighted in Figure 1, BLMK ICB commissions four community MSK providers with contracts and services based on historic clinical commissioning group (CCG) geographies. Following alignment of all contract end dates to 31st March 2024, the ICB is taking the opportunity to assess, evaluate and redesign the Community MSK Services ahead of a formal competitive procurement process due to commence in April 2023.

Current Providers:

- For the Bedford Borough and Central Bedfordshire population is Circle Integrated Care. Circle works in partnership with Bedford GP Practices and local hospitals to provide a range of MSK therapies and treatments, with referral to hospital care when appropriate.

- For the Luton population is HCRG Health Group (previously Virgin Care). The HCRG service works in partnership with Luton GP Practices and local hospitals to provide a range of MSK therapies and treatments, with referral to hospital care when appropriate.
- In Milton Keynes there are currently two providers of MSK services within the community, working in partnership with the local GP Practices and hospitals to provide a range of MSK therapies and treatments. These are Connect Health (providing first level physiotherapy) and Ravenscroft Health (providing advanced physiotherapy, treatments and onward referrals to Hospital services).

Figure 1. Overview of BLMK MSK Providers [Community MSK providers highlighted in yellow]



Goal and Approach

The overarching goal for an effective MSK pathway is to support and empower people to manage their MSK health. When an MSK illness presents, patients have rapid access to support and experience a truly integrated care pathway that is personalised to individual needs and preferences. This goal helps the ICB to deliver two of its strategic priorities – Priority 2: Live Well and Priority 3: Age Well.

The approach to the assessment, evaluation and redesign of the MSK model of care includes five key stages:

1. Developing the Case for Change
2. Defining the services and success factors
3. Procurement of the proposed service
4. Mobilisation and Transition
5. Evaluation and Monitoring

Developing the case for change – progress so far:

An MSK Collaborative was established in 2021 and has been acting as the collaborative voice on the vision and change needed to deliver the MSK programme objectives, whilst assuring quality, safety and value for the BLMK system and our population.

Members include:

- Clinicians and Managers from Primary, Secondary and Community MSK Services
- Representatives from NHS England who are leading regional improvements in MSK care
- Public Health
- A patient representative from Central Bedfordshire

2. Summary of key points:

In partnership with BLMK stakeholders and residents, we have taken a comprehensive approach to assessing the current services and developing the case for change. Some of the findings have led to actions and improvements with the existing service providers. Key findings to date are set out below:

Source	Key Findings
Patient Engagement Survey [Survey August to September 2021, focus groups and events ongoing]	113 respondents (33 Bedford Borough, 46 Central Bedfordshire, 10 Luton and 24 from Milton Keynes). Service users and carers were asked for feedback on their experience of the MSK services in the community and hospital, before the pandemic (68 respondents), during the pandemic (24 respondents) and since the pandemic (21 respondents). Feedback showed that patients had had positive experiences with clinicians. However, waiting times and communications were the main concerns, with complicated pathways, lack of follow-up / post-operative care and poor discharge procedures. Patients also wanted access to more pain management service/techniques whilst waiting for surgery and easy access back into services for management of long term conditions. Holistic and wellbeing focus was found to be a much needed area for potential improvement such as more signposting to mental health services, support groups in a variety of platforms and weight management assistance.
MSK Workforce [Survey in July to September 2021, discussions ongoing monthly]	74 Respondents – 24 from Secondary Care, 26 from Community and 24 from Primary Care. Clinical and non-clinical members of staff experienced variation and duplication of referrals from GP Practices and Community MSK, difficulties communicating across the services, limitations in which services can be accessed by different staff groups, some hospital treatments delayed by community intervention, complicated pathways causing confusion, limitations on record sharing, difficulties in recruiting physiotherapists due to new demands and a reduction in face to face appointments during Covid was seen to be increasing referrals to the Community MSK services and hospital.
MSK Self-Assessment [April 2022 and quarterly refresh]	East of England MSK pathway improvement framework sets out 10 care elements with 48 recommendations for delivering best practice MSK. BLMK have completed an initial assessment against the 48 recommendations which align to a number of areas highlighted through the survey results alongside identifying gaps in pathway/services at place or system.
MSK Health Needs Assessment [Finalised May 2022]	BLMK MSK Health Needs Assessment completed, led by Public Health which has provided a greater understanding of prevention opportunities to improve MSK Health by place and has made 15 recommendations on how MSK care could be improved. The report has indicated that in BLMK - MSK illness a significant contributor to workplace sickness and 20-26% of MSK patients also reporting depression and anxiety. For our places: • Bedford Borough and Central Bedfordshire has a higher age group over 65years, they have a lower incidence of falls and hip fractures and a higher diagnosis of osteoporosis and longer term MSK conditions (as these patients are coming forwards). Therefore, these patients are able to then be tracked on the osteoporosis register in greater numbers. • Luton is more likely to develop MSK illness due to high smoking and obesity rates, but that recorded diagnosis of MSK health problems is low,

	indicating there could be patients that are not presenting with MSK conditions at the onset of symptoms. • Milton Keynes has one of the highest incidences of MSK risk factors in BLMK e.g. smoking, obesity, ethnicity and physical inactivity. Milton Keynes has the highest falls hospital admissions and hip fractures for the patients in the aged over 80 years category. For details of the findings and 15 recommendations, please see **Appendix 1: BLMK MSK Health Needs Assessment- Summary Findings**
Value for Money Assessment [ongoing]	The ICB is currently evaluating a series of data sources to inform current activity and finances, balanced with clinical outcomes to ensure that future services are good value for money. This also includes the development of a set out clinical outcome measures that will ensure the services are improving MSK patients health and wellbeing and that the service integrates with other aspects of the MSK pathway.

Following patient and provider feedback, there was an underlying theme that the pathways were too complicated and fragmented, and communication needed to be enhanced for all users.

Based on this feedback, work has already taken place to improve referral routes, decreasing the need for additional GP tasks e.g. Community Physiotherapists being able to refer directly to Podiatry, and Hospital Physios able to refer directly to Community Services, whereas previously the GP was required to write the referral; this saves time for both patients and GPs.

Nationally, work is underway on the Shared Care Record to allow clinicians better knowledge of patients before and after they have been referred.

The Community MSK services have also increased their face-to-face consultations, and waiting times for treatment are now decreasing across BLMK. NHS services were impacted across the system as a direct result of the pandemic. The system currently continues to restore services in line with national required trajectories to pre-pandemic levels. The Community MSK services across the system have been working hard to try to reduce the waiting times across the area.

MSK Engagement Plan - Strengthening the patient voice as a catalyst for change.

Centric to building a fit for purpose model is ensuring that critical opinion has been sought to guide and steer future foundations. The ICB has reached out to our BLMK lived-experience experts – our patients, and our clinical expert stakeholders.

We continue to ensure that service users and professionals are involved in designing the new service model in order to understand what has worked well prior to, during and after the Covid-19 pandemic and use that when looking at the MSK service both across BLMK and ensuring users' needs are met at place, particularly where there is a high rate of MSK risk factors i.e. smoking and obesity.

During the month of November 2022 – the ICB have been working with residents in BLMK to listen to their experience of the MSK pathway and listen to their views and ideas for the future of MSK services in BLMK. Building on the existing engagement set out in the case for change, BLMK ICB were keen to ensure residents who were unable to complete or attend prior engagement had the opportunity to share feedback.

Focus groups were organised to discuss the work that had been carried out so far, what patients felt would make the biggest difference, and ideas for future transformation. The focus groups took place face-to-face in venues across BLMK, online via MS Teams, and individual telephone contacts. This was to

allow people to have a variety of opportunities to feedback in a method that was most suitable to their individual needs. Members of the team also attended over 50's Well Being Festivals and gained feedback from patients and showcased the planned focus groups to raise awareness.

The MSK Patient Focus Groups were advertised via various methods and groups including:

- All patients that had expressed a willingness to take part again in future engagement during the 2021 survey were contacted and invited to take part in the focus groups
- The 4 current Community MSK providers were requested to advertise the focus groups within their services. This was to ensure that were targeting the existing service users to gain their lived experiences and feedback.
- Information sent to GP surgeries with request to share with their patients and Patient Participation Groups
- Social Media campaign via Twitter, Facebook for both online and face to face focus groups (See Campaign promoted on BLMK website)
- Information sent to Town and Parish councils with request to share with their parishioners the social media posts and display posters
- Support from local Healthwatch to promote focus groups on their websites and mail shots
- The BLMK ICB Communications team shared information via the VCSE organisations (including articles in newsletters)
- Commissioners reached out to Versus Arthritis and National Rheumatoid Arthritis Society (NRAS) – who displayed on their social media feeds
- Requests to local authority partners to share information via their Faith leader, Community and covid champion networks
- Information was shared with members of the BLMK Engagement Collaboration (Engagement leads from the Health and Care Partnership) to cascade via their networks

Table 2. provides a list of engagement activities that have been carried out or are planned:

Date	Place	Event	Type of Event and Venue	Signed Up	Attended
07.10.22	Central Bedfordshire	Festival for Older People	The Rufus Centre, Steppingley	N/A	Approx. 100
19.10.22	Bedford	Ageing Well Festival	The Corn Exchange, Bedford	N/A	Approx. 100
02.11.22	Central Bedfordshire	MSK Patient Focus Group	Flitwick Football Centre, Flitwick	12	5
04.11.22	Milton Keynes	MSK Patient Focus Group	Milton Keynes Christian Centre, Milton Keynes	10	4
08.11.22	Bedford	MSK Patient Focus Group	St Andrews Church Hall, Bedford	1	0
11.11.22	Luton	MSK Patient Focus Group	The Hat Factory Arts Centre, Luton	7	5
16.11.22	Online	MSK Patient Focus Group	Online via Microsoft Teams	30	5
22.11.22	Online	MSK Patient Focus Group	Online via Microsoft Teams	17	3
Range	Telephone	1:1 Conversations	Via Telephone	5	5

Patient questions have been framed in an open-ended style to allow unlimited feedback. Patients have been asked at each session:

- How well supported did you feel along your treatment pathway?
- How well informed did you feel?
- Did you know who to contact if your condition changed?

- How easy was it for you to rearrange your appointment?
- How would you like to be contacted? (Method and frequency for each stage)
- What would have improved your experience and how would you have liked to be supported?
    - while you were waiting for treatment?
    - when you were having treatment?
    - after your treatment had ended?
- Anything else you would like to share/let us know?

So far, insight from the focus groups has been fundamentally valuable in hearing the lived experiences of our patients. Much of the feedback has been focussed towards the method and delivery of information, consistency in communication and waiting times. For example:

- Method of communication: patient choice is necessary – what works for one doesn't for another – this must be highlighted on the referral template. Email, text and online portal methods were popular
- Frequency of communication: Immediate confirmation of referral receipt and triage outcome – to include the next steps i.e. average length of wait what to do if condition changes, generic exercises to do while waiting, how they will know what is happening next i.e. 'you will receive updates every X weeks'
- During treatment - written plan of treatment including what to do (exercises & diet), referrals that have been made elsewhere e.g. social prescribing, IAPT, how long this part of the treatment will take, pain management options, next steps, joined up system i.e. patient does not have to repeat their story
- After treatment - who to contact now if condition changes, continuous exercises for waiting well, pain management options

3. Are there any options?

Utilising feedback and recommendations received to date alongside the ongoing discussions that are planned, in addition to underlying themes shared in the initial engagement and recent engagement, it is felt that there is a significant insight into what would improve patients journeys through the MSK services. The information gained continues to be factored into a redesigned model of care with ongoing input from BLMK stakeholders.

BLMK ICB are happy to provide a further update to the Working with People and Communities Committee in 2023 setting out the proposed new model of care for MSK and how residents views have been listened to and incorporated, if required.

4. Key Risks and Issues

The MSK engagement plan has been shared with the four local authority OSC committees, there is a risk that there could be a view that insufficient patient engagement has taken place and a recommendation that further is required. Whilst further involvement is included in the plan, if the recommendation is for significant additional work on top of this, there is a risk that this could impact the timeline of the project.

The effect of this risk materialising could cause reputational damage to the ICB, ongoing increased procurement risk, potential loss of provision should existing providers not be willing to continue beyond 01/04/2024 which will significantly impact patients care and support, loss of enthusiasm within the project and commissioning team, increased resource requirements for ICB staff and ongoing fragmentation of services for the BLMK population.

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

ECD10
ECD11

5. Are there any financial implications or other resourcing implications, including workforce?

Due to unique circumstances during 2020/21 (nationally directed acute block contracts, launch of the Increasing Capacity Framework and the risk of procurement challenge), NHSEI became concerned with the Circle contract arrangements. Following a series of discussions and escalations, NHSEI supported the recommendation to award a two year extension to Circle, provided that the CCG provide ongoing assurance that the procurement timetable was on track.

In April 2022 TILT were asked to approve a recommendation to extend the four MSK contracts by one year (plus one) to enable a comprehensive service review and further model development with the two Care Alliances. This was supported. However, it was noted main risk associated with the recommendation to extend by a further year is the risk of procurement challenge due to the length of time the existing contracts have been secured (Circle = 9 years to March 2023) and financial value (£15.2m of which Circle is £11.2m). This risk will be mitigated by publishing a market notice which will clearly define the rationale set out in this report, alongside a detailed timeline setting out how the ICB will secure new provision from 1st April 2024.

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

Click to view Green Plan

Innovate and adopt new models of care and ways of working – help to support sustainable future modelling. The HNA has highlighted areas where efficiencies can be made by better collaboration between providers and digital solutions are recommended to increase self-management and reduce the need for patients to travel for treatment thereby reducing emissions
Facilitate better collaboration to enhance efficiencies and deliver positive impact
Support of green social prescribing
Redesign care pathways
Facilitate digital transformation – including virtual outpatients, exercise toolkits and assessments and improved digital communication and MDT working

7. How will / does this work help to address inequalities?

Through market appraisal to help with best placed services, recognising needs based assessments.

The MSK HNA has been produced looking at the population by place and highlighting areas where improvements are required, especially regarding prevention of MSK Conditions. The overall MSK Service Redesign will tackle the imbalance of access to services across BLMK ensuring that patients can access services faster and closer to home as appropriate.

8. Next steps:

Patient engagement will continue throughout the redesign process, including patient representation on the procurement panel, a patient development group to test and refine the proposed model through to supporting the transition to new contracted arrangements. Patients from each of the 4 places will continue to be involved and consulted with though the re-design process.

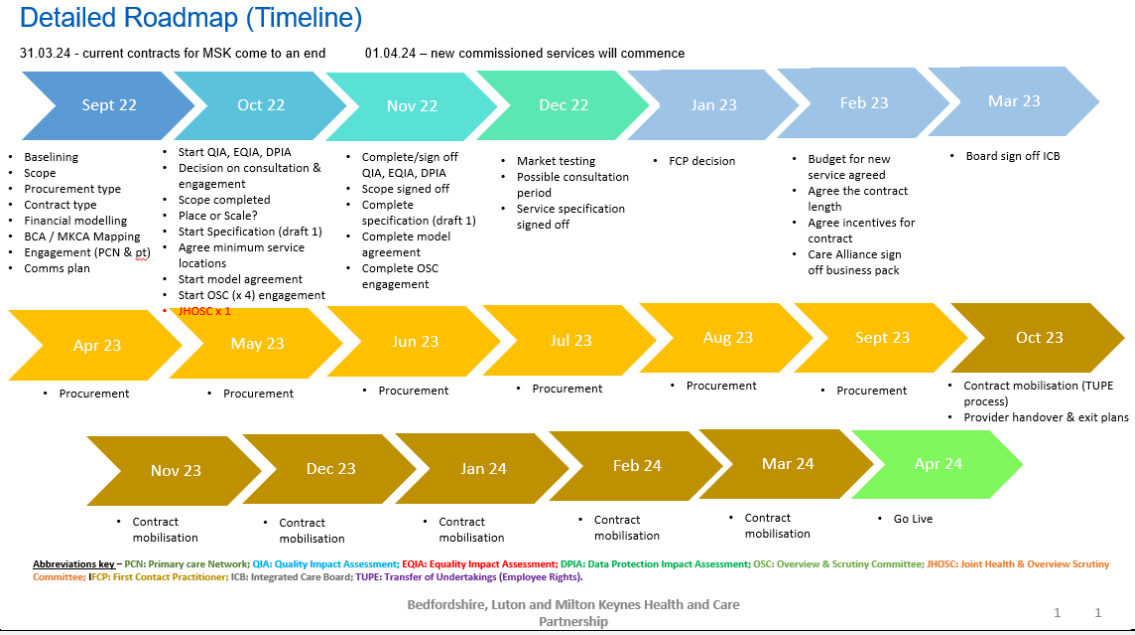
Patients that attended focus groups will be consulted at regular intervals for feedback on proposed service models and specifications.

Patients will be invited to be members of the procurement panel to ensure patient viewpoint continues – critical to this will be their support within the patient led questioning of the tenders. Recruitment processes will be put in place to ensure that there is representation from all 4 places within BLMK.

Models and service specifications shared with Practice Patient Participation Groups (PPGs) to gather further insight and opinion.

The ICB plans to undertake provider site visits to gather patient views and hear more of their lived experiences. The Commissioners would like to undertake this collaboratively with support from other sectors such as Healthwatch and other voluntary organisations to ensure impartiality when collecting patient views.

We expect this engagement to continue throughout the next 2 years during the procurement, mobilisation and go live stages of the new MSK service model.



9. Appendices

Appendix A – Health Needs Assessment Summary

10. Background reading

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

MSK Health Needs Assessment Action Plan

June 2022

1 What was the purpose of the MSK Needs Assessment?

BLMK-wide review of MSK services currently in progress due to expiration of local community contracts. The MSK HNA was commissioned to feed into the models of care to be commissioned and help shape and define the way health services should be delivered.

The HNA outcomes highlighted:

- High burden of disease from MSK conditions and large morbidity from common MSK conditions
- Areas of unmet need
- Cost implications on health and social care services
- Prevention should be a focus
- Future needs projections, for example:
  - Population size and aging
  - Changes in risk factors (e.g. obesity)

2 Scope of the MSK HNA

The three groups of MSK conditions that are used in this needs assessment are obtained from the Global Burden of Disease:

1. Inflammatory conditions
2. Conditions of MSK pain
3. Osteoporosis and fragility fractures (falls pathway covered in a separate area)

3 Impact of Covid on MSK Services

During 2020, routine elective orthopaedic procedures and consultations were cancelled leaving a back log of patients waiting to be seen.

In October 2021, 2,350 patients were waiting for procedures and a further 4,350 for consultations.

In November 2021, over 4,000 patients were waiting over 10 weeks for treatment in the community, half of these were for level 1 Physiotherapy.

In the community, there are multiple challenges in the services:

- staff sickness or redeployment
- lack of appointments and increased waiting times.
- increase in complexity of patients
- potential communication gap between clinicians and patients

A BLMK wide Recovery Plan is in place with national performance monitoring to ensure waiting times are reduced to pre covid levels

4 Action Points Arising

The following action points are grouped as following:

- Prevention
- Reducing Demands on Acute Care
- Streamlining Pathways
- Worthwhile waiting and Prehabilitation
- Performance Management
- Pain Management
- Pain management and Mental Health

Prevention

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Recommendation	Action	Owner
Promote physical activity in all ages	BLMK To have full visibility on wider plan and ascertain if improvement programmes are required	Local Authority and Public Health
Increase smoking cessation support, targeted to areas of higher prevalence	BLMK To have full visibility on wider plan and ascertain if improvement programmes are required	Local Authority and Public Health
Strengthen MSK service links with the falls prevention pathway, which is currently under review	Ensure referral pathways are in line with best practice guidance and embedded in the new Community MSK model which encompasses collaborative processes between all services	BLMK ICB

Reducing Demands on Acute Care

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Recommendation	Action	Owner
Self Management	To increase access to community interventions ensure 111 DOS includes information on self management for MSK and signposts to digital services	BLMK ICB
Self Management	To increase access to digital interventions – Artificial intelligence referral/management apps, information websites, ensure 111 DOS includes information on self management for MSK and signposts to digital services	BLMK ICB
Multidisciplinary Care models	Increase access in Primary Care to: • First Contact Practitioners • Social Prescribers • Health Coaches • Care Coordinators	Primary Care

Streamlining Pathways

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Recommendation	Action	Owner
Lean and Clear Pathways between Primary, Community and Secondary Care	New model to ensure referral pathways are standardised, equitable and clear with a single point of access for all patients To ensure robust models of pre op screening in place to identify comorbidity at the earliest point in patient pathway whilst awaiting definitive treatment	BLMK ICB
Diagnostics pathway in place to support early diagnosis	Ensure diagnostic hub model provision is able to provide sufficient resource and capacity to Community MSK services to support referral to treatment times	BLMK ICB

Streamlining Pathways

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Recommendation	Action	Owner
Communication routes between patient, GP, Community and Secondary Care services streamlined and informative	• Regular MDTs between referrers and providers • Frequent Attenders at Primary and Secondary services identified and managed through expert MDTs • Include Care coordinator role within Community MSK service to ensure patients and referrers are fully informed and patients are safety netted • To ensure clinical systems interoperability/communications are in place • Enable digital (or patient held) records similar to patient passports which are accessible by all stakeholders inline with accessible information standards	BLMK ICB

Worthwhile Waiting and Prehabilitation

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Recommendation	Action	Owner
Assistance should be provided for patients awaiting definitive treatment to ensure they do not deteriorate	Ensure new service model has full MDT approach which will include: • Social Prescribers • Care coordinators • Physiotherapists and Advanced Physiotherapy Practitioner • Pain Nurses and Consultants • Mental Health professionals e.g. psychologist • Referral pathways with other Allied Health Professional groups including Podiatry, Occupational Therapy, Diet & Weight Management Care coordinators in Community MSK Service to ensure patient pathway includes signposting to self-help groups, exercise classes, weight management, pain management, social services, Occupational Therapy (OT) and IAPT to ensure they are fit for treatment and therefore better outcomes To understand the offering and platform required for surgical and joint schools in the secondary care pathway to ensure patients are fit for surgery and prevent deterioration	BLMK ICB ELFT CCS EPUT CNWL BHFTs MKUH

Performance Management

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Recommendation	Action	Owner
Contract management should ensure standardisation of service performance and provision across BLMK	Identify and agree the KPIs for Community MSK Providers within 2022/23 to enable informed decision making and benchmarking All Community MSK Providers contracts to include standardised KPIs	BLMK ICB
Minimum data sets should be standardised across services to enable informed decision-making and benchmarking	Identify and agree the minimum data sets for Community MSK Providers within 2022/23 to enable informed decision making and benchmarking Ensure Community MSK Providers contracts include standardised Minimum Data Sets	BLMK ICB
There should be standardisation of outcome measures across BLMK in community services	Work with NHSE to ensure nationally recognised outcome measures are embedded in the Community MSK Contracts	BLMK ICB

Report to the Working with People and Communities Committee
11 – System-wide Coproduction Training Plan

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

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

Report Author	Rachael Bickley (Co-production Lead)
Date to which the information this report is based on was accurate	29/11/2022
Senior Responsible Owner	Maria Wogan Chief of System Assurance and Corporate Services

This report has been presented to the following board/committee/group:
To be presented to the Engagement Collaborative December 2022

Purpose of this report - what are members being asked to do?
The members are asked to **note** the following: A) The ongoing coproduction training plan

Executive Summary Report

1. Brief background / introduction:

In response to feedback and lived experience from residents and coproduced system strategies with residents and service users, and in compliance with the ICB duty to include resident communities in the development of health care services conferred by the Health & Social Care Act, (2022), and Working with People & Communities Statutory Guidance published by NHS England, (2022), the BLMK ICB "Working with People and Communities Strategy" identified coproduction and collaborative working as key strategic pillars.

Whilst there are key pockets of practice within BLMK demonstrating development of and delivery care through coproduction, many areas are yet to start on this journey. As identified in the NPT analysis below, Co-production is not the "business-as-usual" way of working for much of our health and social care system. This coproduction training plan seeks to support all ICB key priorities by supporting staff members and partners to increase resident participant involvement in both their ongoing staff training and service development.

The training plan is the result of engagement with over 140 ICB/ICS staff members and an initial Normalisation Process Theory Analysis, identifying key aspects of current system working that aid or prevent collaborative working and resident participation in service development.

2. Summary of key points:

2.1 the ICB/ICS have a duty to involve resident communities in the development and delivery of health and social care.

2.2 There is a varied starting baseline of understanding and application of coproduction throughout the ICB/ICS.

2.3 The proposed approach supports initial standardisation of the workforce knowledge base, provides ongoing support and targeted assistance for staff and community members to implement collaborative working.

3. Are there any options?

N/A

4. Key Risks and Issues

- Staffing resources may limit the ongoing training development and support available.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒
[If yes, please add your Risk Ref (from 4Risk) here**]** **[**If no, please explain why here**]**		

5. Are there any financial implications or other resourcing implications, including workforce?

There are financial implications for:

- Provision of continued support for ICB/ICS members whether through direct coproduction team support or from VCSE partners.
- Development of new starter training
- Re-development of current system training to include service users.

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

Supporting ICB/ICS staff to coproduce health and social care services will support community redesign of care pathways to achieve net zero emissions and digital transformation of solutions which are congruent with, and better supported by the local community, thereby increasing the success of transformation implementation.

7. How will / does this work help to address inequalities?

Training staff members to effectively engage with underserved communities will develop initial and existing relationships with residents suffering the deepest inequities in health. It is essential these relationships are built and well maintained to prevent deepening or introducing cultural distrust of service organisations.

Increasing involvement of resident participants from communities experiencing inequitable health outcomes will support personalisation of services, increasing uptake and participation in community health goals.

8. Next steps:

1. Initial ICB/ICS training has been commissioned from The Consultation Institute with a pilot to run on the 8th & 9th of December with full roll out of initial training commencing in January 2023.
2. The coproduction support pack is in development with delivery due in January/February 2023
3. The initial skills development programme has begun with the coproduction team supporting “Digital Care Delivery” through initial coproduction planning session in January. Further opportunities for teams to consolidate learning and receive practical project support to be advertised and facilitated.
4. Exploration of training opportunities for ongoing staff training
5. Understanding of financial capability to support ongoing training and support for coproduction.

9. Appendices [please list]
10. Background reading

BLMK ICB Co-production Training Plan

Introduction

Increasing and sustaining collaborative working through coproduction of local health and care services across BLMK is a key priority of the BLMK ICB and required through health care legislation and statutory guidance. Whilst there are currently members of the ICS supporting mature systems of service coproduction, some collaborating at a surface level, and others are yet to work in this way.
To develop the capability of ICB and ICS members and partners to develop their work in this way, the co-production team have explored current ICB staff experiences, barriers, and support requirements.

Collaboration

6 engagement activities and events including the med ops team, nursing directorate, previous feedback received from the medical directorate in October and specific sessions including commissioners, directors and service planners were held between October and November 2022. 3 exercises were conducted face-to-face at events being held for the medical and nursing directorates, and 2 were held online for service commissioners and ICS partners. Over 140 members of staff have offered their thoughts on coproduction training and/or creating a culture of coproduction.

Captured themes

During the event discussions staff members identified immediate and future training needs, suitable formats and required timings for training. There were 3 common structures of support identified, an agreed baseline training; ongoing support and further skills development (see table 1).

Baseline Training

The NHS Working with People & Communities Statutory Guidance, (2022) identifies the need for co-production of health and social care at all stages of health and social care development, including strategic planning, research, quality improvement, as well as design and delivery.

Participants requested an agreed BLMK definition, with better understanding of their responsibilities, and practical approaches to implementation coproduction plans in their area of work. Participants agreed an initial training package was required to support all board members, staff and partners in their understanding and delivery of co-production or collaborative working. Training should be open to all as the current understanding and implementation of co-production and collaborative working is so varied, and the experiences of staff and partners currently working in this way will benefit the learning of others with less experience on the course.

Ongoing Support

The move to a more collaborative approach to work may be quite transformative for some areas of NHS working. There was agreement a single source of trusted resources was required to support coproduction. Main concerns were “building bridges” and relationships to increase access to resident

groups, understanding how to facilitate and plan for co-production, and how to fund both the projects and resident participant involvement.

Developing Skills

There was recognition that some NHS teams do not have much experience in co-producing services and would welcome a mentorship approach to early projects. Further skills were also requested such as project management, data analysis skills and case study writing which would be supported with an ongoing training plan.

Our learning transformation

As mentioned previously, the starting base for co-production across BLMK is variable and for some this way of working will be quite transformative. Transformative learning in known to be challenging for participants, especially for those further away from the desired goals. The ongoing support and skills development are keys aspects of the training plan which will support consolidation of the baseline programme, and implementation of skills.

Diagram 1 illustrates both the level of ongoing commitment required to learning and skills development after the initial training and the expected timeline. Whilst the starting based is varied, the required knowledge and skills also vary depending on role and contribution to embedding and implementing coproduced services across BLMK. For example, board and committee members will have support from their training to support resident participation in strategy development and outcome prioritisation, whilst service delivery managers, service and community leaders will need to explore identification and development of community engagement at place.

Engagement participants also identified a need for further service user training and support in coproduction. This is currently being explored with further service user events scheduled for December 2022 and will be included in the implementation plan once completed.

As co-production is a key pillar in the BLMK “Working with People and Communities Strategy”, co-production training should be developed for both existing board and committee members, new starters as part of core competency training. This will require both initial training (which has been commissioned from the Consultation Institute, commencing in January 2023), and development of ongoing training for new starters and integration into staff core competencies.

Training plan actions

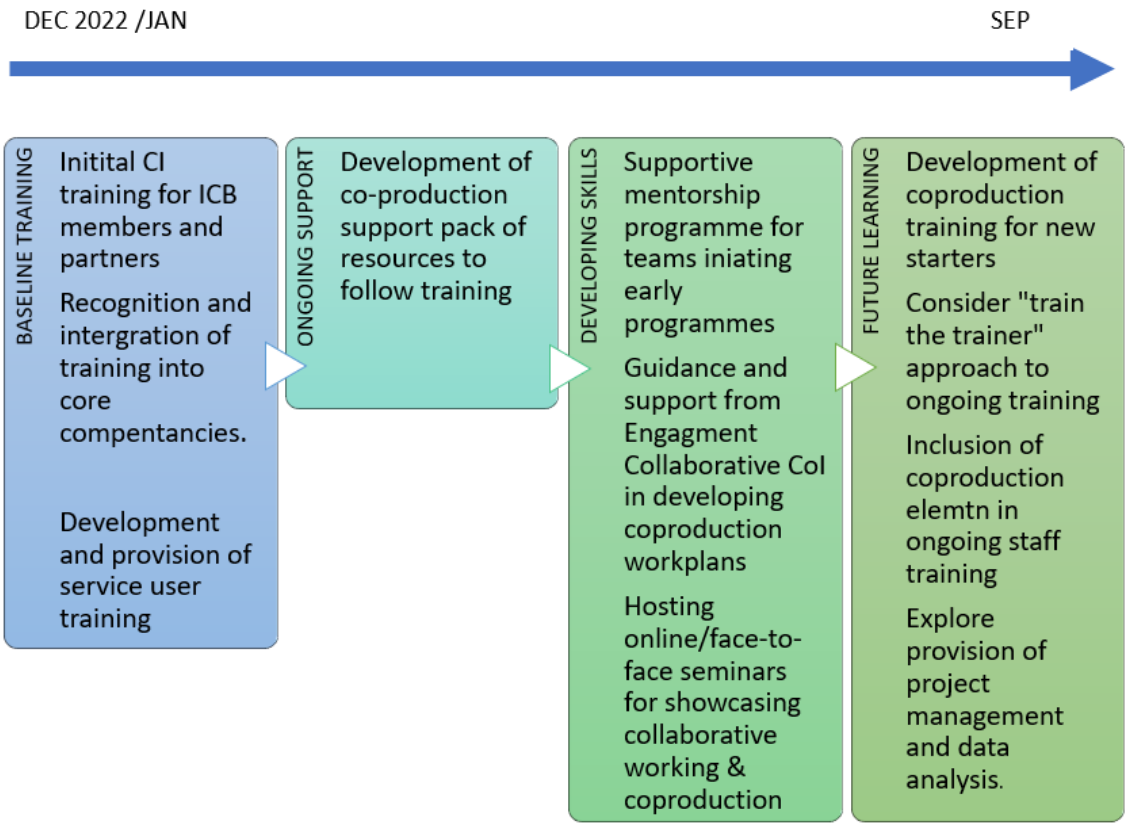


Table 1: Identified structures of support and content

Baseline Training	Ongoing Support	Developing Skills

• A baseline skill level and expectations including:
  ○ Defining agreed definition of coproduction, within the defined strategy and layers of collaboration
  ○ Knowledge of responsibilities
• Guidance on best practice, including:
  ○ Methods of collaboration in person and virtual spaces.
  ○ Engaging with diverse groups, and guidance on stakeholder engagement (who we should be talking to)
  ○ Creating safe spaces to collaborate
  ○ Ways to support digital inclusion or prevent digital exclusion
  ○ Realistic timescales to aid planning
	• Creating support package including:
	  ○ How to guide on payment policy for service users.
	  ○ Case studies where coproduction has/is working well.
	  ○ Checklist to facilitate coproduction
	• Ongoing support for coproduction plans from the engagement collaborative
		• Team supports for initial coproduction projects in teams with little experience in collaborative working
		• Future training required in the following areas:
		  ○ Data analysis
		  ○ Quality improvement
		  ○ Project management
		  ○ Case study writing

Table 2: Identified formats and timing

Format	Timing
• Mix of online & face-to-face • Interactive sessions • Not on ESR – avoid e-learning • MDT training • Example case studies • Consistent and updated	• Built-in to new starter training • Protected time for training currently employed staff

Appendix A – Coproduction NTP Analysis

Embedding Coproduction – The BLMK Approach

The NHS as a whole unit is divided into smaller ecosystems of care. The introduction of a system wide approach to care development and delivery is a particularly complex intervention. Normalization Process Theory has been found to consistently evaluate context and develop successful implementation strategies for interventions changing working practices in health care. The theory supports consideration of social structures and norms contributing to uptake of interventions across complex systems.

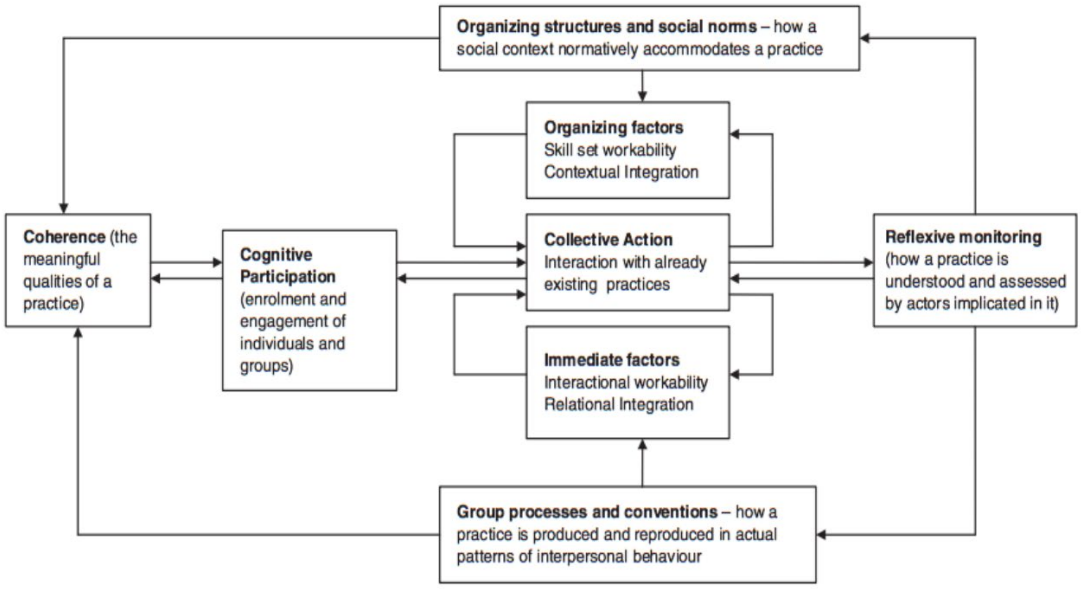


Figure 1: Normalisation Process Theory (May & Finch, 2009)

The following initial analysis is a consideration of the social and material context within which the coproduction of health and social care services are to be embedded in BLMK ICS. It is not a static assessment but will evolve as a greater understanding of the social and material context of the system is realised through engagement with staff, organisation, and residents within BLMK ICS.
Information informing the analysis has been taken from multiple staff engagement events between October and November 2022 involving over 140 ICB/ICS staff.

NPT Components	Questions to consider within the NPT framework	NPT Evaluation of Coproduction in BLMK	Actions	Progress
Coherence (i.e., meaning and sense making by participants)	Is the intervention easy to describe?	There are differing definitions understood and being implemented across BLMK. This is causing friction between stakeholders as some do not value the work of others as co-produced if it does not fit their recognised description.	Develop a collaborative definition of Coproduction for inclusion in the Collaborative Working Strategy	Achieved - Initial definitions of Coproduction agreed and written into the Working with People and Communities Strategy
	Is it clearly distinct from other interventions?	Co-production is not a distinct practice as it includes co-planning, co-decision making, co-delivery and co-evaluation of services.	Encourage acceptance of varying states of coproduction at different stages, and for different purposes, with value recognised in all collaborative working.	
	Does it have a clear purpose for all relevant participants?	There appears to be some confusion between equity planning and coproduction of services for purposes outside of equity (i.e. service quality and efficiency) within the funding arrangement. There is reported inequity of understanding, and capacity to coproduce amongst both service users and staff.	Establish relationships with bid developers to educate and influence increased consideration of cost of coproduction work for inclusion in all bids. Develop training and supportive facilitation packages for staff and service users.	Achieved – Meeting with Matt Hollex and initial agreement on principle of VCSE and coproduction team involvement in bid support. Meeting being arranged with finance team to support development of funding strategy for coproduction
	Do participants have a shared sense of its purpose?	All stakeholders seem willing to improve health and social care services, and there is outward agreement that collaboration is key, with inclusion of coproduced services as a key strategic goal. However, if this is not followed through with financial support to develop coproduction in all areas it may reduce the value perceived by some stakeholders.	Work to develop financial plan supporting coproduction. Provide opportunities for positive case studies of coproduction for learning, supportive mentoring opportunities.	See above RE financial plan. In progress - Case studies being collated and developed for delivery at webinars starting in January. Full timetable arranged for Jan, Mar, May, July 2023 In progress - Training strategy to be completed and mentoring programme to be planned and facilitated, suggestions made for VCSE and Coproduction team support for this.

	What benefits will the intervention bring and to whom?	Staff, service users and commissioners will find services more efficient, cost effective, and see improved health outcomes. If coproduction is appropriately targeted with health inequalities as a priority, services uptake and effectiveness amongst vulnerable populations will increase.	Amplify benefits of coproduced services in education and training. Ensure community groups experiencing widest inequalities in health are at the centre of collaborative working projects.	See above RE webinar events. Achieved - Produce stakeholder map of community assets within geographical areas of deprivation in BLMK Ensure evaluation support available within the intended framework.
	Are these benefits likely to be valued by potential participants?	This is yet unknown as work needs to be done regarding staff and service user engagement. Reports of some residents being unhappy collaborating with known institutions and organisations in Luton. By all means not all but should be aware that not all residents may trust or want to work with known health authorities.	Develop opportunities for collaboration and gauging of current relationship between stakeholders and collaborative working.	Achieved - Staff engagement events have identified support needs and barriers to collaborative working. Study planned to explore service user views of current coproduction opportunities.
	Will it fit with the overall goals and activity of the organisation?	Yes, coproduction has been identified as a key strategic goal.	Need to ensure that action follows the rhetoric. Community representation at all levels of the ICS.	In progress - development of service user representation plan almost complete and ready for discussion at Engagement Collaborative. Initial funding secured. Ongoing support for funding will be needed to support service users in ICB collaborative roles.
Cognitive participation	Are target user groups likely to think it is a good idea?	Some staff may see this as peripheral to their main task of delivering patient care.	Training and communication programme to support learning and increasing value. Developing community and staff champion roles for coproduction. Creating links between these key collaborators. Ensuring renumeration package is adequate for staff and service users. Imperative to	Coproduction at service level has yet to be explored fully. The mentorship programme has been identified as a possible support for whole team working on coproduction programmes and could support consolidation and implementation of coproduction learning.
(i.e., commitment	Will they see the point of the	Projected benefits may not be obvious.		Community Connectors roles are already existing and

and engagement by participants)	intervention easily?		secure increased in value held.	may be helpful in supporting as community champions. A discussion to be had around this with the engagement collaborative.
	Will they be prepared to invest time, energy and work in it?	Staff may not be insufficiently motivated to invest thought and energy into changing their practice.		RRR policy in development and first draft to be finalised once initial concept explored with the finance team.
Collective action	How will the intervention affect the work of user groups?	Increased time requirements form both staff and service users Cost implications for service user need to be addressed both in terms of increasing engagement and ensuring no loss of income for service users already experiencing financial difficulty. Increased individual and community engagement with health Better communication of working difficulties and service limitations for service users Better understanding of service users experience, individual needs and responsive personalisation of care.	Work with service managers to identify process and opportunity for staff champions. See above regarding financial need and incentive. Develop collaborative forum to build critical mass of positive development with coproduction. Ensure service user and staff experiences are well publicised.	Coproduced framework to be considered in the new year. See above re financial plans Achieved - Engagement collaborative developed into Community if Interest. In Progress - See above RE: Training, promotion, and participation.
	Will it promote or impede their work?	Ultimately, co-produced services should be easier to deliver, at better cost and more accessible to service users. However, it may cost more to implement infrastructure initially and due to time needs, it may not make working lives easier initially. It may be seen as a low priority by staff given the timing of winter and increasing covid.	Ensure benefits are measurable and publicised well to develop collective approach. Ensure developed financial plan is available to support coproduction	See above RE: Finance, training, promotion, and participation.
(i.e., the work participants do to make the intervention function)	What effect will it have on consultations?	Co-production on a service development level may change recommended care. Attitudes towards informed decision making may need developing to accommodate a	Provide training and support to establish coproduction at all levels of care from system wide, to 1:1 consultation.	In progress - See above RE: Training, promotion, and participation.

		shared/informed approach to decision making.		
	Will staff require extensive training before they can use it?	Staff and service users will need some training or support to develop understanding of the legal and moral requirements to collaborate on service development.	Develop training packages for ICS staff members and service users. Develop ongoing support workshops for implementation support Develop a business-as-usual approach to change.	Achieved – Initial staff engagement complete. CI training in place for pilot on the 8th & 9th of December. In progress - Recruiting to pilot and developing on going mentorship and webinars.
	How compatible is it with existing work practices?	Some areas are coproducing care well whilst others are yet to start on the journey there is wide variation.	Develop Training, support and incentives to increase participation and collaborative working. Start small and grow, use existing examples to illustrate benefits and methods.	See above RE: Training, promotion, and participation.
	What impact will it have on division of labour, resources, power, and responsibility between different groups?	Overall, there will be a power shift from a hierarchical approach of service planning and development to a shared approach to developing service and adoption of ideas. This requires a shift in resources to support the community to engage, but also to support staff to lead in collaborative roles.	Influence key strategic partners to increase available resources to service users and staff working in collaborative role (development of staff and community champions) Ensure SUV representation in all areas of the ICS.	See above plans re: representation, training, financial plans. Continue to represent at opportunities such as the ICB board as on 25/11
	Will it fit with the overall goals and activity of the organisation?	Yes, coproduction has been identified as a key strategic goal.	Representation at ICB groups to follow core ICB priorities, 20+5 and Denny review recommendations. To increase diversity and develop key public health priorities.	See planned CoI representation plan to be discuss and agreed with CoI and WPAC
Reflexive Monitoring	How are users likely to perceive the intervention once it has been in use for a while?	Depending on collective value added to coproduction, and sustainable development and management of relationships and resources, coproduction should be seen as a benefit to improving services.	Explore baseline understanding of coproduction at present. Develop coproduction opportunities to develop framework for BLMK	Baseline studies being explored at present. Future coproduction events to explore framework development.
(i.e., participants reflect on or	Is it likely to be perceived as advantageous	Service users should be able to see and experience the changes they have worked with, making their services	Develop resident engagement events to build momentum for working collaboratively	Develop initial resident engagement events in line with the

appraise the intervention)	for patients or staff?	more accessible and personal to their needs. However, what good production looks like to different communities can be quite fluid and will need to be explored together as the framework is developed.	in geographical areas of historically low engagement, and with community groups experiencing health inequalities as a priority. Coproduce collaborative framework with residents, service providers (including VCSE), and commissioners	now completed staff engagement. Establish collaborative workshops with multiple stakeholder groups to develop coproduction frame-work for BLMK
	Will it be clear what effects the intervention has had?	Identifying benefits of coproduction can be difficult to isolate due to complex relationships between differing resources and interventions.	Early identification of evaluation data needs and supportive evaluation of services for continued development.	See above re coproduction of framework. Ensure evaluation built into development
	Can users/staff contribute feedback about the intervention once it is in use?	It is important that evaluation is built into the process at the start. Areas of expected improvement (qualitative and/or quantitative should be identified as early in the process as possible to ensure data is collectable. All stakeholders should have an opportunity to evaluate and redevelop the service if it is not working as expected.	Continued support for facilitating community engagement events to collate and interpret service evaluations.	See above re coproduction of framework. Ensure co-evaluation built into the framework
	Can the intervention be adapted or improved based on experience?	Yes, coproduced services will not provide the appropriate service for all time. As populations change and develop, the service needs will also. Periodic evaluation must continue within the coproduction cycle.	Develop system process to continually update experience and effect data for service development.	See above re coproduction of framework and co-evaluation.
Group Processes and Conventions	How a practice is produced and reproduced in actual patterns of interpersonal behaviours.	Currently Coproduction happens in quite an ad-hoc way in some areas depending on timescale, funding, staff knowledge of involvement and ability to engage with commissioned involvement services. From initial engagement there is an appreciation of the value of involvement but some scepticism from both staff and residents around “tick-boxing” and how meaningful involvement has/can be. Engagement with VCSE, Inequality and Training events	Develop a systematic approach to supporting coproduction including funding, building cultural expectations to coproduce work, training and ongoing support for staff to implement coproduction programmes of change.	Initial conversations around financing coproduction at a system level are yet to commence. Coproduction events to be held to develop a framework for coproduction. See above re: training and support programme currently underway

		has indicated service developers and clinicians brining pre-made solutions to named coproduction events for engagement and consultation rather than true coproduction solutions.		
Organizing factors	Skill sets, workability and contextual integration	As mentioned previously there are varied perceptions and implementation practices regarding coproduction across the system. Current barriers identified by staff members include timing, finance and accessibility to the community stakeholders. <u>Timing</u> The timescales expected for delivery of development programmes is short comparative to the necessary time required to effectively coproduce solutions. Frequently good intentions to coproduce are affected by this (and finance) which undermine efforts and motivation to coproduce at the next opportunity <u>Finance</u> There is no agreed approach to funding coproduction within the system with different partner organisations holding different policies, and others not financing coproduction work at all. This may be interpreted by staff and community members as a lack of perceived value in both community participation and the concept of coproducing health and social care services thereby reducing participation. <u>Accessibility to Stakeholders</u> Engaging with underserved communities is often considered as difficult and described as such with terms such as “hard to reach”. Activities can be difficult to access for communities experiencing inequities, and without the time and finance to support and build relationships, local communities are not able to engage with opportunities to collaborate.	A long-term plan for workflow timing to be considered. This should support greater available time to deliver local health and care changes, including earlier start times for planning development of larger programmes such as the annual Winter Plan. Development of a sustainable financial plan to support coproduction and inclusion of resident partners at all levels of the ICB and ICS. Integration of coproduction plans and funding into business case/care change submissions. Support for ICB/ICS coproduction projects via oversight from the WPAC and Engagement Collaborative Community of Practice, supporting wider integration and financial support for coproduction via collaboration with VCSE partners. Co-ordination of coproduction requests could be supported through the engagement collaborative community of practice to suggest amalgamating collaborative opportunities projects where possible. This should both decrease overall workload and	Explore timescales and workflow opportunities to examine current workflow and timescales, aiming to integrate coproduction over longer planning phases where possible. See above regarding financial planning, in addition develop sustainable funding flow for coproduction work to be supported by VCSE Development of engagement collaborative to ensure resident participation. Develop workflow proposal for coproduction projects to be developed in collaboration with the collaborative. Explore and develop initial capacity and capability of BLMK Insight bank.

		Utilisation of VCSE Members VCSE partners are a vital aspect to delivery of coproduction at place. However, challenges in providing support including obtaining financial support and experiencing workload overwhelm. A combination of limited financial recompense for VCSE involvement and increasing numbers of departments needing to engage both limit the capacity for VCSE involvement, and risk disengagement by VCSE partners who are unable to support multiple projects.	reduce risk of disengagement. The development and appropriate use of an insight bank of collaborative working could also support registration of local collaborative events offering opportunities to reduce overlap and repetition of work.	
Organizing factors and social norms	How a social context normatively accommodates a practice	The predominant method of NHS project management has historically been inclined towards Waterfall approaches of project management. This method results in groups of commissioners and practitioners exploring best known clinical practice or case study practices, producing a larger goal solution, and consulting with community representatives to agree, or develop further. Coproduction however leans more towards an AGILE approach whereby all stakeholders are represented at the evaluation and solution development stage, with iterative adjustments in development until a collectively agreed solution is achieved. This difference in approach to developing health and social care may produce conflict in moving to a more AGILE approach to both identifying service challenges and their appropriate solutions. The waterfall project management approach leans towards perpetuating hierarchical role structures between health care providers and residents.	Supporting individual teams to develop their localised plans, encouraging and AGILE approach to working through mentorship. Ensure shared practice is promoted through regular webinar events, including the “how” of the work not the just the “what”.	See training plan

Pain Management

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Recommendation	Action	Owner
Specifically for lower back pain, primary care services should consider how to risk stratify young people and adults presenting with a new episode of low back pain with or without sciatica based on biological, psychological, and social factors	Primary care to look into best practice models of risk stratification to create and implement a local model for identifying patients at risk of lower back pain	BLMK
Use of opioids should follow clinical guidelines	To ensure local JPC guidelines adhered to when prescribing opioids To ensure patients undergo regular medication reviews if prescribed opioids	BLMK ICB Primary Care
Use of opioids spinal injections, and imaging should follow clinical guidelines	To ensure best practice clinical guidance is adhered to when prescribing opioids, administering spinal injections and accessing imaging for chronic pain patients	BHFTs MKUH

Pain Management and Mental Health

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Recommendation	Action	Owner
To increase access and engagement to Pain and Mental Health services, a hybrid digital and face-to-face service should be offered, and patient outcomes should be monitored for these initiatives	To ensure integration between mental health and pain management services providing smooth, aligned and concurrent pathways To ensure patient choice is at the forefront of decisions on how patients access services i.e. digital or face to face or combination To ensure inequalities around access to digital and face to face services are considered in pain management programmes and patient choice discussions	BLMK ICB Community MSK Providers BHFTs MKUH ELFT CNWL
There should be a higher level of awareness of mental health needs in community MSK services, e.g. physiotherapist and GP to consider IAPT referral in chronic MSK patients	To ensure full MDT approach is embedded in community services to include Mental Health interaction at each stage of pathway to create a culture of 'Mental Health First'	BLMK ICB Community MSK Providers

Pain Management and Mental Health

Recommendation	Action	Owner
The system should ensure patient records are shared between relevant services as appropriate to improve patient care e.g. community MSK service and IAPT to improve patient care	• Regular MDTs between referrers and providers • Frequent Attenders at Primary and Secondary services identified and managed through expert MDTs • Include Care coordinator role within Community MSK service to ensure patients and referrers are fully informed and patients are safety netted • To ensure clinical systems interoperability/communications are in place • Enable digital (or patient held) records similar to patient passports which are accessible by all stakeholders inline with accessible information standards	BLMK ICB

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the BLMK Integrated Health & Care Partnership Board
12 – BLMK Integrated Strategy (draft)

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

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

Report Author	Hilary Tovey, Interim Director of Strategy
Date to which the information this report is based on was accurate	6th December 2022
Senior Responsible Owner	Anne Brierley Chief Transformation Officer, BLMK

The following individuals were consulted and involved in the development of this report:
BLMK Integrated Care Board Members Chair, BLMK ICP
This report has been presented to the following board/committee/group:

Purpose of this report - what are members being asked to do?

The members are asked to review and comment on the following:

A) The content

B) The communication style – relevance and accessibility to the public and partners

C) Contribute to the discussion on the communications approach to publicise and engage residents, local communities and staff with this strategy

Executive Summary Report

All Integrated Care Systems are required to publish their Strategy by the 1st January 2023. This is a core document setting the context and population needs to inform our planning and delivery at Place and Provider Collaboratives, with collective oversight and peer-accountability through the Integrated Care Board.

In BLMK, we recognise that this first iteration is a 'mobilisation' strategy, giving the initial steer to Places and Provider Collaboratives as we prepare our first formal integrated Plans during Quarter 4 for operational delivery in 2023-5.

The audience for this document is:

- Local residents
- NHS, Local Authority and public sector partners who contribute to the health & well-being of our communities
- Voluntary, community and social enterprise organisations working within our communities

BLMK Integrated Health and Care Partnership Board members are asked to review and comment on this first draft, with specific consideration to the questions as above.

1. Brief background / introduction:

The ICS' Strategy is owned by the Integrated Health & Care Partnership, whose role is to act as 'custodian for population health' supporting and enabling the improvements to health outcomes and tackling inequalities outlined in the Strategy. This role is in 3 parts:

1. Review and approval of the Strategy itself
2. During Q4, approval of Place and Provider Collaborative operational delivery plans, specifically whether
    a. the actions identified are clearly linked to specific inequalities or health outcomes in local populations that will be improved through these plans
    b. there is a clear approach to co-design and co-production with residents and local communities
3. Highlighting and connecting public sector and voluntary / social enterprises which through working in partnership can achieve more for our population

The attached DRAFT Strategy is circa 85% complete. We wanted to seek your input into it at this stage to help create a strategy that

- Reflects our population and communities in BLMK
- Suitably reflects our 5 strategic priorities
    - Start Well
    - Live Well
    - Age Well

- Growth
- Tackling Inequalities

- Reflects our commitment to subsidiarity (Place), with planning, decision-making and delivery as close to the resident as possible
- Emphasizes our ambition to go further using our partnerships to support residents to live longer, and live more years in good health, especially the central role played by VCSE in supporting residents to thrive
- Speaks of real examples that make a difference to local people

2. Proposed Strategy finalisation & publication – actions & timescales

NHSE guidelines to Integrated Care Boards outline the expectation that these first Integrated Care Partnership strategies will be shared with partners and published on the ICB website no later than 1st January 2023.

It is proposed that comments will be received until Friday 16th December, after which a final version will be circulated and published by 1st January 2023.

The final documents will have links to supporting strategies, such as the ICB People Strategy and the Clinical Services Strategy.

3. Use of Strategy to Inform and Assure Operational Planning at Place & Collaborative

During Quarter 4 of 2022-3, the ICB will need to oversee the development of the 2-year operational delivery plans. Whilst some of this will encompass the NHS planning cycle for NHS organisations, it is proposed that a simplified version of this is undertaken (in line with expected planning guidance from NHSE), with resources in the ICS freed up to support Places and Collaboratives finalise:

- Their operational plans to deliver together at Place
- Clarity on which populations will benefit – improving health outcomes and tackling inequalities
- Clear metrics for measuring the impact of Place / Collaborative delivery plans in improving health outcomes and tackling inequalities, supported by progress milestones

It is proposed that the Health & Well-Being Boards (as well as Place Boards) review these plans locally before the Integrated Health & Care Partnership Board reviews the Place operational delivery plans and assure themselves of the above for all BLMK residents in March 2023.

It will be the role of the ICB to undertake the assurance of delivery and outcomes through triangulation of Place plans with this finalised strategy, and workforce and financial plans.

4. Key Risks and Issues

Key risks relate primarily to the development and delivery of Place and Collaborative Plans to deliver local improvements in line with this Strategy during this ongoing period of high demand pressure and constrained resources.

Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☐	No ☒
Any unmitigated risks will be added following discussion and review at the Integrated Health and Care Partnership meeting on 14th December 2022.		
5. Are there any financial implications or other resourcing implications, including workforce?		
The ICS will run a streamlined NHS planning cycle during Quarter 4, freeing up resources to support Places and Collaboratives with their delivery plans and associated metrics to measure impact for local populations.		
6. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan		
This is a clearly defined priority in the Strategy		
7. How will / does this work help to address inequalities?		
This is a clearly defined priority in the Strategy		
8. Next steps:		
The next steps are outlined in sections 2 and 3 above.		
9. Appendices		
Appendix A -		
10. Background reading		

BLMK
Integrated Care System

Bedfordshire Luton and Milton Keynes Health and Care Strategy

November 2022

Contents

Our vision is for everyone in our towns, villages and communities to live a longer, healthier life

Your health and wellbeing matters to us.

But we know the experience of using health and care services is not always as easy as it should be. And that there is more we can do to support our residents to live longer, and live more of those years in good health.

That's why we are publishing this strategy. It aims to make sure everyone involved in your health and care is working much more closely together, including your local Councils and your NHS.

We use the money we receive from your taxes to help our residents have good health and care at each stage of life. To Start Well, Live Well and Age Well.

This strategy sets out what we want to improve, and how we will work together to achieve this.

By April 2023 we will have published our two-year Delivery Plan. It will clearly show the steps we will take in 2023-2025 and how our work will be measured.

Our work is based on partnerships. With you and your family. They are also with community groups who keep people connected and well, as well as your Councils and your NHS.

We know times are tough. But together we can, and will, improve services to help you, your family and community to thrive.

ADD SIGNATURE – CLLR STOCK

Our Purpose

Bedfordshire, Luton and Milton Keynes Health and Care Partnership aims to improve the health and wellbeing of our population.

The Partnership is made up of local Councils, NHS service providers and voluntary sector partners in your area. We are looking to answer three questions to help us change services for the better.

1. **Are we doing the right things to improve health outcomes and tackle inequalities for all our residents?**
2. **Are we making the best use of the partnerships between public services, VCSE and local communities?**
3. **Are we working with local communities understand what matters to our residents and co-design and co-produce sustainable solutions with them as equal partners?**

This Strategy sets out our ambition for improving health outcomes and reducing inequalities.

It shows how we will work together, and what this will mean for people and communities across Bedfordshire, Luton and Milton Keynes.

The Mandate of our Integrated Care System is to…

improve outcomes in population health and healthcare

tackle inequalities in outcomes, experience and access

enhance productivity and value for money

help the NHS support broader **social economic development**

The people of Bedfordshire, Luton & Milton Keynes

Our area covers four places **Bedford, Central Bedfordshire, Luton and Milton Keynes** – all vibrant, unique and rich in cultural heritage. Our population is diverse with more than 100 languages spoken.

With **2 million jobs** we are one of the fastest growing economies in England, contributing **£110bn** to the economy. We are served by excellent air, rail and road transport links.

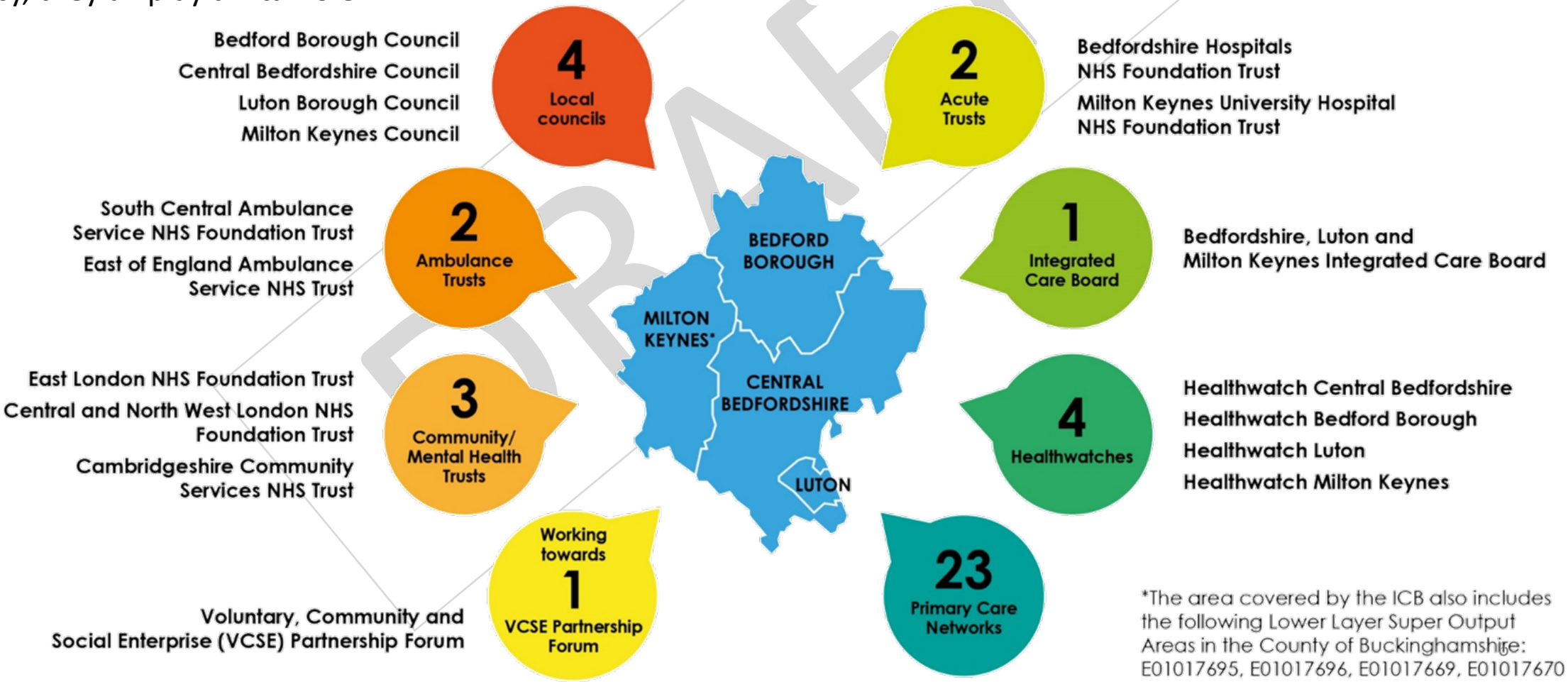
BLMK has a **diverse population**. Of our population of one million people, 69% identify as White British, 13% Asian, 8% 'Other White' and 6% Black.

We are one of **the fastest growing areas in the country.** Our population is expected to exceed **1.2m** within the **next decade** and could increase by nearly **90%** by **2050**.

The Health and Care Partners in BLMK

Here you can see many of the organisations which make up the Bedfordshire, Luton and Milton Keynes Health and Care Partnership. From local Councils providing education and housing and the NHS, through to the police and ambulance services who are there in an emergency, they all play a vital role.

Partners also include people in our communities, businesses and universities, as well as many voluntary organisations. All can help to promote health and wellbeing, and grow our economy.



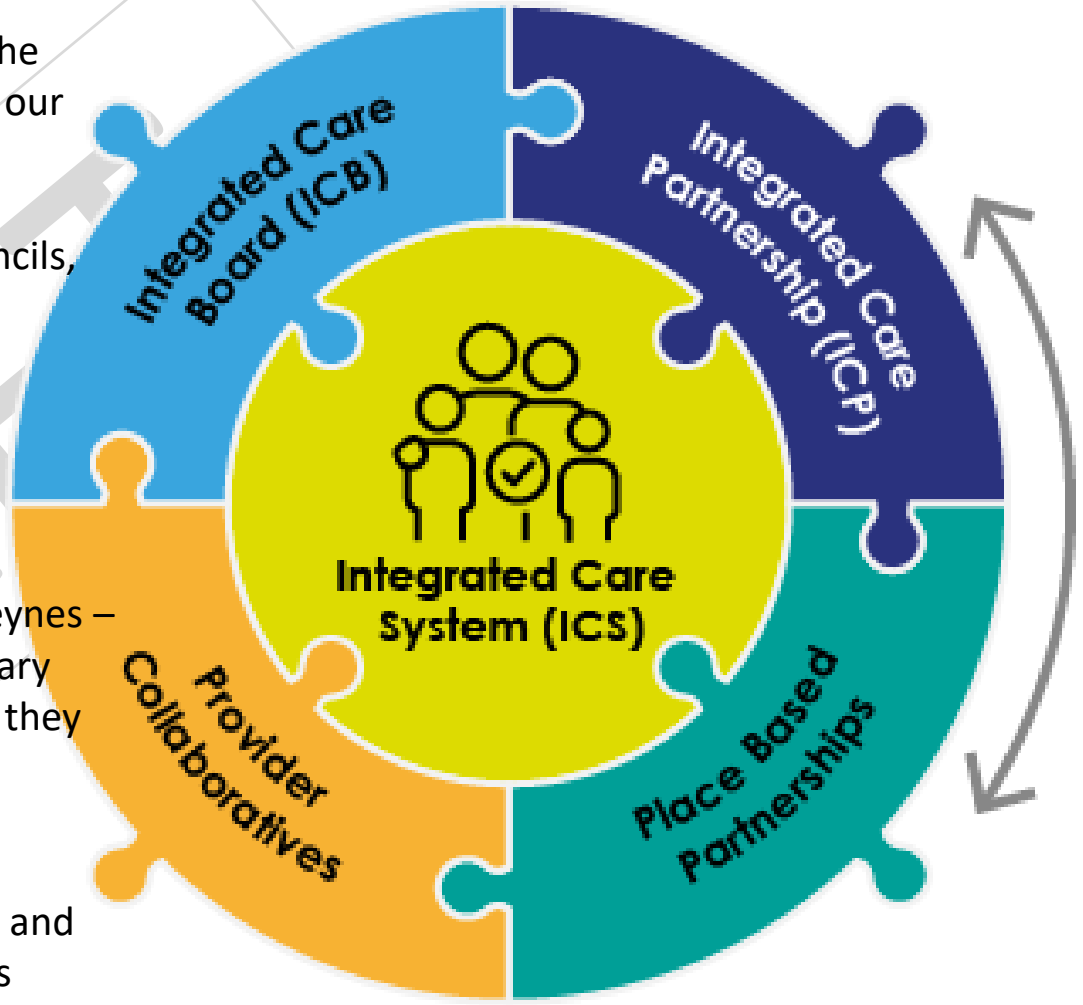
How our partnership will work together

All partners, including Healthwatch and the voluntary sector, come together at the **BLMK Health and Care Partnership** to oversee the development and delivery of our integrated care strategy.

The **BLMK Integrated Care Board** brings together senior leaders from yourr councils, NHS and voluntary sector. They hold collective responsibility for our actions to:

- Improve outcomes in population health & healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social economic development

Each local council – Bedford Borough, Central Bedfordshire, Luton and Milton Keynes – across has a **Place-based partnership** at which the NHS, local council and voluntary services agree priorities and take decisions about services for their residents, so they meet local needs.



Provider collaboratives are groups of providers working together across a wider geography than at place. In our area this includes the Bedfordshire Care Alliance and the All-Ages Mental Health, Learning Disabilities and Autism Collaborative, and is supported by the East of England Children and Young People Provider Collaborative.

At the heart of our system are the new **Neighbourhood Teams** which are combined NHS, local council and voluntary sector teams working in partnership with a group of GP practices. Much of the proactive and preventative care for local residents is delivered by these teams.

Our overarching ambition is…

To **increase the number of years** people spend **in good health** and **reduce the gap** between the **healthiest and least healthy** in our community.

This is the right goal but it is ambitious and will take a long time to achieve. The impact of COVID and the cost of living challenges have made it harder.

The only way to achieve it is by working together. Our Health and Care Partnership allows us achieve more for residents than by working as separate organisations. The image to the right shows the different activities needed to achieve our goal, with the needs of our residents at the centre of everything we do.

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

OUR PURPOSE

Where we* will focus our efforts

Our Health and Care Partnership has five priorities which will inform our work. These focus on how we want to improve health outcomes for people of all ages.

They reflect the importance of economic growth and sustainability in tackling inequalities. These inequalities could be in health outcomes, or social factors such as housing, employment and isolation.

These priorities are supported by seven enablers. These are areas of work which will help us to make progress.

For each priority we will use our data on population health to help us understand where there may be inequalities, and identify the actions we need to take to address them. This could locally, or across the wider area.

We will focus our actions through place partnerships.

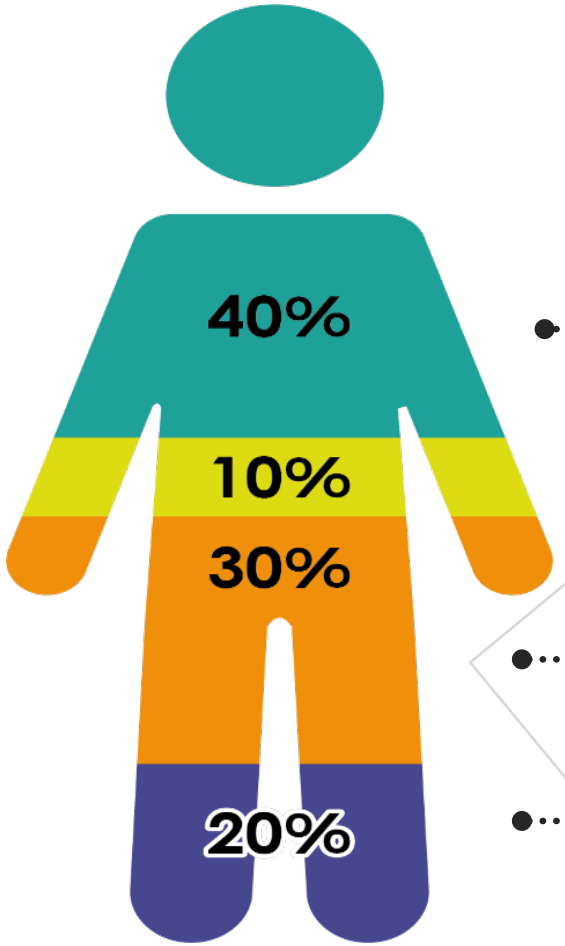
*** Where 'we' means our whole system: our population, families & friends, our communities, our Councils and NHS, people working in the public sector, businesses, universities, charities and other voluntary, community and social enterprise organisations.**

What do we Need to Do to Support Our Communities to Thrive?

There are lots of factors that affect our chances of living a **longer, healthier life**.

Access to high quality healthcare is very important. But a good education, decent housing, working in a growing local economy, keeping active and enjoying time with other people all have an important part to play.

In many ways these factors that affect a person's health are all connected.



- **Socioeconomic factors**
- **Physical environment**
- **Health behaviours**
- **Healthcare**

That's why we are developing closer and more collaborative ways of working with residents, communities, voluntary sector, your Councils and NHS.

This partnership enables us to provide better joined up care to you and your family, and allows us achieve more for residents than by working as separate organisations.

Supporting Our Residents to Live Longer, healthier lives

We want everyone in our towns, villages and communities to live a **longer, healthier life.** This means improving life expectancy and increasing the number of years people live in good health.

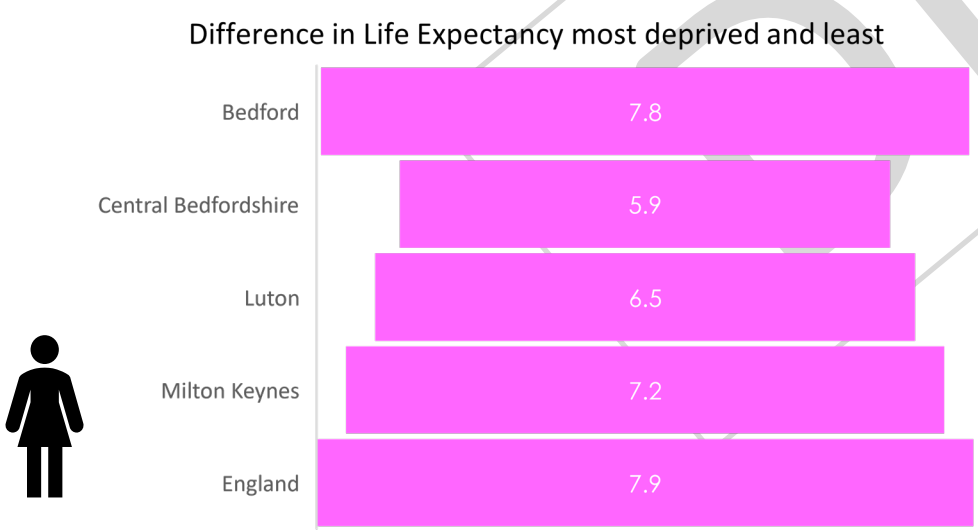
Life expectancy varies widely across our area, and can lag behind other parts of the country. Years lived in good health or without disability are also better for people in some other places.

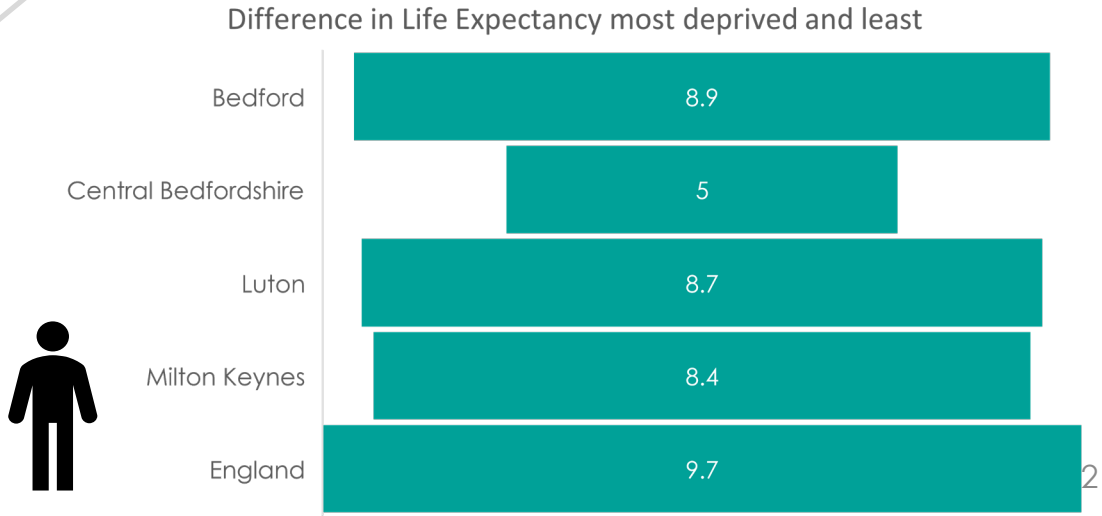
Smoking in our area is higher than the England average and is more common in some population groups. Two thirds of deaths in 50-70 year old smokers are due to smoking.

Up to 40% of our children are **overweight or obese**, more in the most deprived children. This can lead to serious conditions like diabetes and asthma, and reduce life expectancy.

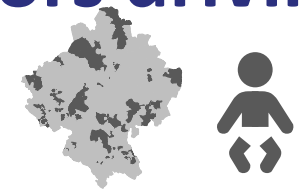
Over half of UK households will live in fuel poverty by January 2023. Living in cold, damp houses increases the risk of pneumonia and asthma, and worsens airway disease, heart attacks, strokes and poor mental health.

Air pollution has a significant impact on health and inequalities and is already responsible for around 6% of all deaths in Bedfordshire, Luton and Milton Keynes.





Factors driving our health challenges

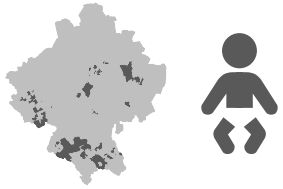


A child from the most affluent areas of BLMK

54%
achieve 5x GCSEs A* to C overall (2015/16)

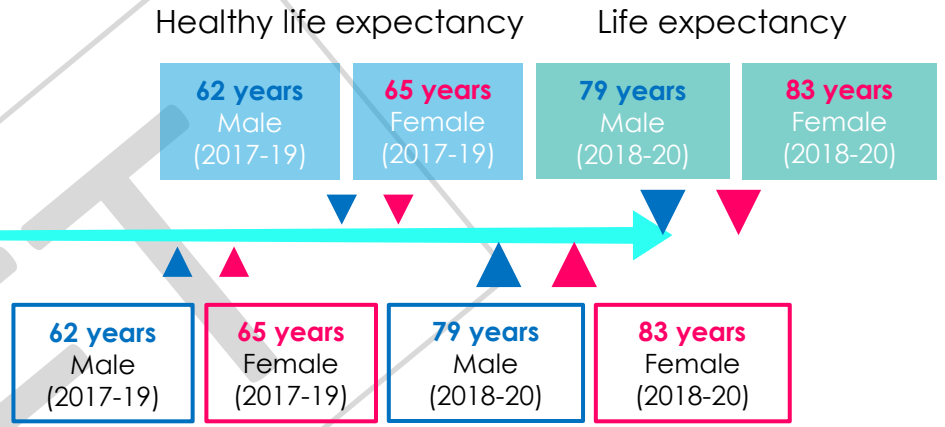
19%
Percentage of adults who are smokers

A child from the most deprived areas of BLMK



30%
achieve 5x GCSEs A* to C eligible for FSM (2014/15)

34%
Percentage of adults in routine and manual occupations who are smokers



There are more low birth weight babies than the England average. This increases the risk of childhood mortality, asthma and infections, and diseases in adulthood.

The uptake of childhood vaccinations are low and falling. Uptake is now below the level of strong population immunity.

Waiting lists have lengthened since the pandemic. Stopping face to face appointments was necessary, but now people are waiting longer and more likely to have conditions undiagnosed.

People with a learning disability or autism are less likely to attend for screening, have longer waiting times for treatment and are likely to die 14 years younger than the rest of the population.

Cancer screening coverage varies and is lower in some population groups. Screening can reduce the risk of dying from cancer - by 38% for breast cancer. Cervical screening can prevent 83% deaths from this cancer.

Referrals to mental health services are increasing. One in five people with a long term condition also have mental health needs. People with a severe mental illness are more likely to die earlier, yet 40% missed their health check last year.

The number of people who are registered as carers has nearly doubled since 2019. Carers are twice as likely to have a mental health problem and almost three times more likely to have a long-term condition.

What We Are Going To Do Together*

Start Well

- The first 1001 days of life – Baby and Family
- Enabling our Children to Thrive (staying fit and healthy, managing complex care needs, mental health, supporting those most disadvantaged)
- Successful transition to adulthood

Live Well

- Well-being and Lifestyle – being in control of your life, well-being and health
- Improving cancer outcomes (prevention, detection, treatment and recovery)
- Access to Primary Care – your Neighbourhood Team
- Tackling the big three – cardiovascular disease, respiratory illness and diabetes
- Care tailored to individual needs – Learning Disabilities, Veterans, End of Life Care

Age Well

- Staying Well at Home – falls prevention, Virtual Ward, medicines review, enabling independence, living with dementia
- Tackling loneliness and isolation – staying connected
- Home First after hospital admission - recovery, rehabilitation and reablement

***Together – You, your family & friends, your community, your Councils & NHS**

Tackle Inequalities

- Improve health outcomes to enable people to live longer in good health
- Tackle the causes of disadvantages in life
- Measure the impact of our actions, learn and maximise positive outcomes for residents

Growth

- Grow our local workforce – support residents into training and employment
- Make good use of our resources – people, buildings and money
- Look after our planet
- Support our staff to thrive

The Challenges

Residents' health and care needs have changed over the pandemic

- Children and young people's lives have been disrupted – there are more referrals for safeguarding, and for conditions such as anxiety and eating disorders
- Increased demand for primary care, especially GP and dental services
- Larger packages of care required for patients who need support on discharge from hospital.

Living Well is more challenging for everyone

- Cost of living pressures have risen, and many families are struggling to pay their bills
- Our staff are feeling the effect of their huge contribution during COVID. Vacancies have been steadily increasing – these currently run at nearly 14% for NHS staff and 10% across adult social care - and this further affects staff morale
- There are increases in urgent care needs and challenges to recover elective waits post-COVID

Public Sector Funding Needs to Go Further

- Funding challenge for local councils and the NHS
- Cost pressures for providers and suppliers

Our strengths – what we are proud of

There is no doubt that improving health outcomes and tackling inequalities against the backdrop of increased demand for health and care services, the impact to our population of COVID and the challenges of the cost of living is a real challenge. We will need to work together and much smarter to achieve a greater impact for our residents in the current context.

However, the Bedfordshire, Luton and Milton Keynes Integrated Care system has some real strengths that we can draw upon to help us achieve our shared vision of supporting all our communities to thrive.

- **There is a shared commitment across all your Councils and NHS to improve health outcomes and tackle inequalities**. This is reflected in the work we are already doing to support our residents to live longer, and live more years in health.

- **We have vibrant voluntary, community and social enterprise organisations in all our communities**, whose reach and understanding of residents and their needs is immense – and who are willing to work further with statutory services through formal partnerships underpinned by the BLMK Memorandum of Understanding between the ICB and Voluntary, Community & Social Enterprises

- And **we have strong partnerships between the local Councils and NHS organisations**, demonstrating that we are willing to develop our ways of working together to support our communities to thrive

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

OUR COMMUNITIES

Going Further Through Partnership

Integrating Care through Neighbourhood Teams*

Neighbourhood teams work together to serve a local population of 35,000 – 50,000 people registered with a group of GP practices.

They have 4 core aims:

- **Shared responsibility** for improving the health and well-being of local residents
- **Continuity of care** provided in an integrated way for those who might benefit
- **Streamlined access** to same-day urgent care
- **Proactive identification and intervention** for those most in need

Supporting carers in Central Bedfordshire

Primary Care Networks in Central Bedfordshire are working to ensure that carers are looking after their own health. They have been contacting carers who have not been to see their GP in the last 12 months or who have a long-term condition, to give them a full health check and look at how well they are managing their own health.

The aim is to offer these people a care plan personalised around their needs.

Using population health data to provide personalised care

90% of people who are socially vulnerable live on their own and often contact the out of hours GP services or 999, and sometimes ended up in hospital unnecessarily.

Looking at linked primary and secondary care data. Titan Primary Care Network identified people who could benefit from being reviewed by one of our team.

Jane was one of those people. On visiting her home, a social prescriber found she wasn't managing her health and her home was in a bad state of disrepair. Working with the local council, the team arranged improvements to her home, reviewed her medicines and helped her to better look after herself. She's eating better, able to get out more and feeling less isolated.

***Neighbourhood Teams** include GP practices, community pharmacy, voluntary sector, dental and ophthalmology practices, local authority services, community healthcare services, mental health and learning disability services

It’s All About You

Our aim is to make working with people and communities as equal partners with statutory services a reality in Bedfordshire, Luton and Milton Keynes.

Our principles of co-production are based around recognising and valuing the lived experiences of people in our communities and working together at every stage.

We are making a commitment to work in a way that represents the **views of all our communities**.

We will provide training and support for staff and residents to allow everyone an equal opportunity to get involved in designing and delivering care.

Build Leadership that supports and promotes co-production.

Train staff and citizens in co-production and how to make it happen.

Use open and fair ways to get input from **full range of people** who use services, carers, and communities.

Review and **report progress**: from ‘you said, we did’ to ‘we said, we did’.

Reward and **recognise** people’s contribution.

Embed co-production until it becomes ‘how we work’.

Identify where co-production can have the greatest impact, and **start from there** - involving people in the earliest stages of design.

Making the most of our community

There is a wealth of expertise and local knowledge of our communities in our Voluntary Care and Social Enterprise (VCSE) partners.

They are an essential part of the team to achieve our goals of supporting residents to live longer, healthier lives.

We are working with VCSE partners across Bedfordshire, Luton and Milton Keynes to develop a partnership approach to recognise, support and use their talents.

It will put people in our communities at the heart of everything we do.

Working together to help young people with autism

Leyla, 18, has a learning disability. She was struggling to communicate with professionals and starting to disengage with her care.

She was referred to a new service developed in partnership between the NHS and Autism Bedfordshire. It gives young people a dedicated care worker to make sure they're listened to and fully involved in how their care is planned.

Leyla now has access to a personal health budget, organised by her keyworker. She is involved in a local farm project and her parents have support to better understand her needs.

Bedford Borough

Bedford Borough is one of the largest urban areas in the county of Bedfordshire. It has significant diversity, with 100 different community languages spoken and one of the largest concentrations of Italian immigrants in the UK.

The River Ouse runs through the town. The town has a rich heritage in the lace industry, brewing and aircraft building. Bedford Borough has an elected Mayor and is a commuter town just 40 minutes outside of London.

Bedford Borough's vision is to thrive as a place, that people are proud of, want to live in and move to.

Local plans recognise that this needs a growing and strong local economy and an active response to climate change. From this foundation residents will be able to thrive and realise their potential, supporting and celebrating the diverse and inclusive communities.

Bedford Borough place plan commits to:

- Understanding our communities
- Promoting prevention and health promotion
- Transforming care with primary care and VCSE

Total population ≈ 185,300 in 2021

Age profile:

- One in six people are aged 65 years and over

Diversity:

- 74% White British, 10% Other White, 7% Asian, 4% Black

Deprivation:

- 14% of neighbourhoods are in the most deprived in England.
- 15% of children (5,000) live in low income households.

Use of health services:

- 33% increase in Children's referrals,
- a 25% increase in Adult and 22% in Older Adult referrals.

Central Bedfordshire

Central Bedfordshire is the most rural of our four areas. It is made up of 62 small market towns and villages from Sandy in the north to Dunstable in the south. The large area covered by Central Bedfordshire Council means that one-in-three residents travel to hospitals outside of our system.

Central Bedfordshire's strategic plan focuses on continuing to be a great place to live and work, through: Protecting the environment through comprehensive sustainability plans

- Supporting the health and wellbeing of our 290,000 residents, and ensuring the care of vulnerable residents
- Building schools for the future to meet the needs of all our young people, including those with Special Educational Needs and/ or disabilities
- Delivering homes to meet the needs of all residents Delivering and improving services such as roads and transport

Central Bedfordshire place plan commits to:

- Improving access and supporting healthy choices.
- Supporting independence for older people
- Tackling inequalities and the wider determinants

Total population ≈ 294,200 in 2021

Age profile:

- Almost one in five people are aged 65 years and over, the oldest population in our area

Diversity:

- Nine out of every 10 people identifying as White British

Deprivation:

- only 2% of neighbourhoods are in the most deprived in England.
- Dunstable-Manshead, Parkside and Flitwick contain the most deprived neighbourhoods.

Use of health services:

- 33% increase in children's referrals,
- 9% increase Adult and 8% increase in Older Adult referrals.

Contents

Luton

Luton is the most urban, and ethnically diverse of our four local authority areas, with nearly half of the population made up of ethnic minority groups. Luton has a rich heritage, including the Vauxhall factory, which continues to be a major employer in the town.

London Luton Airport has undergone significant redevelopment in recent years, becoming the country's number one airport for private aviation.

By 2040, the vision is for Luton to be a healthy, fair and sustainable town, where everyone can thrive and no-one has to live in poverty.

To support this, Luton will be:
A town built on fairness – tackling inequality
A child friendly town - Investing in the future of young population
A carbon neutral town – addressing the impact of climate change

The Luton place plan commits to:

- Giving every child the best start in life
- Sustainable communities, and tackling inequalities
- Reducing frailty and supporting independence

Total population ≈ 225,300 in 2021

Age profile:

- On in eight people are aged 65 years and over

Diversity:

- most ethnically diverse population in our area (43% White British, 31% Asian, 12% Other White, 10% Black)

Deprivation:

- one in four neighbourhoods are in the most deprived in England
- 10,000 (nearly one in five) children live in a low income household
- Unemployment levels are high at nearly one in ten of the population (9.6% vs. 5.3%)

Use of health services:

- 66% increase in Children's referrals,
- 18% increase in Adult and 22% in Older Adult referrals.

Contents

Milton Keynes

The city of **Milton Keynes** is the largest place in Buckinghamshire with one of the UK's most successful economies. It ranked fifth highest for business start-ups, with a strong jobs market and lively cultural activities.

Milton Keynes has the youngest population of all our places. A quarter of the city's population are under 18 and just 14% are over 65. It has excellent road and rail transport connections.

Milton Keynes City Council and the city's health partners are taking on additional responsibility together for improving residents' health by improving the local health and care services.

Called **The 'MK Deal'**, they are pioneering new inclusive ways of working.

The Milton Keynes Deal commits to:

- Supporting children & young people's mental health
- Tackling obesity
- Supporting people with complex needs
- Improving how services work together to reduce avoidable hospital admissions

Total population ≈ 287,000 in 2021

Age profile:

- 14% of people are aged 65 years and over

Diversity:

- Ethnically diverse population (73% White British, 11% Asian, 7% Black, 6% Other White)

Deprivation:

- 12% of neighbourhoods are in the most deprived in England.
- 8,500 children (15%) live in low income households.
- Higher levels of employment (68% vs. 65%) than other parts of our area

Use of health services:

- 27% increase in Children's referrals,
- 17% increase in Adult and 13% in Older Adult referrals

Provider Collaboratives: mental health, learning disabilities and autism

Our mental health, learning disability and autism services already work closely together. We are now forming a Provider Collaborative to tackle issues such as:

- **Workforce** – We have invested in mental health services so that all people can get rapid and fair access to care. We need to train a new generation of mental health professionals so we can expand our services.

- **Emotional wellbeing for young people** – Since the pandemic, the number of young people referred to mental health services has increased. We are opening, Evergreen, a new children and young people's mental health in-patient unit called Evergreen, which is due to open in January 2023. We also need to work with our partners in each borough to offer early support for young people in distress, which is joined up with family, schools and communities.

- **Supporting Adults with Autism** – A high proportion of adults with autism don't have a formal diagnosis. This can limit their access to support for them, their family and their employer. We are working with Autism Bedfordshire to understand the needs of these people, and improve the experience of adults with Autism and Asperger's syndrome.

Working in partnership to support people in crisis

The Mental Health Street Triage service works to ensure patients experiencing a mental health crisis in Bedfordshire and Luton have fast access to care.

The scheme involves a police officer, paramedic and mental health professional teaming up in one car to respond to mental health crisis calls 365 days a year. Operating from 12pm-12am, the team attend incidents where there is an immediate threat to life – someone threatening to self-harm, or commit suicide – or where someone has called the police or ambulance and expressed concern for someone.

The team has a dedicated phone and can be referred to incidents by police and ambulance control rooms.

Provider collaboratives: Bedfordshire Care Alliance

It's essential that care is joined up between hospital, social care, community and primary care. This is especially important for residents who need support on discharge from hospital.

Bedfordshire Care Alliance is a Provider Collaborative, which focuses on the aspects of integrated health and care that are best done for the whole of Bedfordshire.

Some of the Alliance's priorities are:

- **Home First** - Providing care at home to help people with frailty recover as quickly as possible after a hospital visit. This may include a short stay in intermediate care for rehabilitation.
- **Stay Well at Home** - Extending the virtual ward so that people can be cared for at home if hospital admission is not required, with medical, nursing, therapy and care support
- **Ensuring communities have fair access to resources** for Neighbourhood Teams, and support for Home First and Stay Well at Home

Insert case study on acute pressures and virtual wards

Working in partnership to support people in crisis

The Mental [illegible] to ensure patients ex[illegible] Bedfordshi[illegible]

The scheme involves a police officer, paramedic and mental health professional teaming up in one car to respond to mental health crisis calls 365 days a year. Operating from 12pm-12am, with bases at police headquarters in Kempston and at Luton Police Station, the team attend incidents where there is an immediate threat to life – someone threatening to self-harm, or commit suicide – or where someone has called the police or ambulance and expressed concern for someone.

The team has a dedicated phone and can be referred to incidents by police and ambulance control rooms.

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

WHAT THIS MEANS FOR ME & MY FAMILY

What Can I Expect to be Different?

No-one Left Behind

The NHS provides universal healthcare

Local Authorities serve their populations in all civic areas, including social care, schools & education, planning & housing, waste and recycling, children & young people, transport, roads & parking, leisure, environmental services, community safety

The way we provide our services makes a big difference in how they are used by local residents. In turn this can impact the health & well-being of residents.

We are determined that the way we provide services is fair and accessible to all in BLMK

Luton's family partnership service

The Family Partnership service provides intensive support to our vulnerable children, young people and their families.

We strongly believe that children belong in natural networks with people they know and who will love them and keep them safe. We expect all practitioners and managers to prioritise this value, and to help children have safe permanent relationships as a basic entitlement.

There are many approaches that the service may use to identify the support and this may include:

- direct support by a family support worker
- identification of services either commissioned or provided by other partners within the community or specialist services

Prevention

There is a saying that ‘prevention is better than cure’.

Prevention includes actions to keep people well, such as supporting independence for longer to enable older people to live at home for as long as possible.

This includes Falls Prevention Checks, undertaken by Bedfordshire Fire Service in people’s own homes. Officers check for trip hazards at the same time as advising residents of fire safety measures, such as smoke alarms.

With the resident’s permission, the Fire Service can also refer people for advice on housing, and stopping smoking.

Prevention also includes early diagnosis of serious conditions such as diabetes, so that lifestyle changes can help improve health.

Preventing diabetes in Milton Keynes

Diabetes is a big problem in our area. Doctors wanted to know how to support more people, particularly from the south Asian community.

To do this, they used data to find out which people were likely to be at risk of diabetes, and then test them for the condition.

Nasreen is a young mother from Luton who was diagnosed as pre-diabetic after blood was taken by her GP.

She has been referred to the diabetes prevention programme, piloted in Luton and now rolled out across Bedfordshire, Luton and Milton Keynes. This has helped her to understand how lifestyle changes, such as to her diet and exercise, can help to improve her health. These changes can help her to avoid complications associated with diabetes.

Tackling the Causes of Poor Health

It is not just illness and injury that cause poor health and wellbeing. Our life circumstances and environment also have an impact.

In each of our Places, we are determined to work with residents to tackle the causes of poor health and wellbeing.

Supporting local people through the Lighthouse project

The Lighthouse is a co-produced mental health drop-in service staffed by fully qualified NHS mental health professionals and trained volunteers in Leighton Buzzard, Bedfordshire.

Inspired by carers and service users and led by trained volunteers, the service is designed to be accessible for all people. The team can help everyone from those feeling lonely or isolated, people with worries about practical issues like applying for benefits, those who want support as part of their recovery, or anyone who feels they are close to or experiencing a mental health crisis.

Tackling the cost of living crisis in Bedfordshire

With more people experiencing poverty as a result of increases in cost of living, we are working collaboratively across the system to find ways to support the most vulnerable.

Most people say that their health has been negatively affected by the

Rising cost of living, mainly due to

heating and food bills going up.

Bedford Borough Council is using funding from our Integrated Care System to provide warm spaces where residents can get a hot drink and join in activities with others. Volunteers are also on hand to advise on issues from managing their bills to homelessness and loneliness.

Start well: Every child has a strong start in life

Our most disadvantaged babies and their families are offered tailored support through the first 1,001 days of life.

All our children are enabled to thrive. They have the tools to stay fit and healthy. They have support to manage complex care and mental health needs, with extra support for the most disadvantaged children.

Young people are ready for adulthood, and supported across health and care services as well as through education and into employment.

Transforming lives in Milton Keynes

There are a significant number of young people who experience serious harm, violence and abuse in Milton Keynes. Thames Valley Police, Milton Keynes Hospital and YMCA MK volunteers are working in the Emergency Department at the local hospital to help young people affected by these serious issues.

Ben is one of the young people who is using this scheme. He has been given a dedicated keyworker to provide one-to-one mentoring, coaching and support to help him break out of the cycle of violence.

Live well: People are supported to manage their health and wellbeing

People have control of their life, well-being and health and access to services and tools they need.

Care is built around neighbourhood teams that deliver support in communities, with accessible primary care at its heart. And personalised to meet individual needs – using at innovative ways to support the whole person.

Rapid mental health support, focused on prevention and supporting people with mental health conditions to stay well.

More conditions are prevented and detected early so they are easier to manage and treat – particularly heart disease, respiratory illness, diabetes and cancer.

Care is tailored to an individual's needs – for example, Learning Disabilities, Veterans, End of Life Care

Improving cancer outcomes in Luton

Nam lives in Luton. She was invited to a routine smear test last year, but because her GP is male she delayed going. When Nam learned she can see a female practice nurse, the results show that she has cervical cancer.

She's referred to Mount Vernon Cancer Centre for radiotherapy. But because Nam can't drive and her husband can't get time off work, she chooses not to have treatment and is now on a palliative care pathway.

The Luton Cancer Outcomes project, which brings in partners from the local Council, NHS and VCSE sector, is looking at how we can change this story in the future.

Using information about outcomes, and the barriers to care, partners are working to find solutions that work for local people. Targeting those people who aren't coming forward for screening and providing specific support, including transport, to help people get the care they need.

Age well: People age well, staying healthy and independent for as long as possible

Older people are supported to stay well at home. With a focus on tackling loneliness and isolation, people will stay connected to their community and neighbourhood teams to get the help they need.

Support to maintain independence. Community services, including falls prevention, virtual wards and medication reviews, will help older people to maintain independence. It will allow them to manage long-term conditions, including dementia.

People are supported with recovery, rehabilitation and reablement after a period of illness, at home or in hospital.

People are supported to die at home if that is their wish, with support for them and their family.

Supporting people with dementia

D's GP practice referred her to Working Together Leighton Buzzard team (WTLB). The programme that brings together GP practices, mental health services and social care to coordinate care.

The WTLB team reviewed D's case. A visit was arranged with the district nurse and social worker the following day. They assessed D and created a care plan with her husband. They referred her to an occupational therapist referral and ordered a new bed so she could comfortably and safely sleep downstairs.

Her husband was assessed as the main carer and was offered any necessary support. D's medication was reviewed and, after speaking with her GP, further medication was prescribed to improve her breathing.

By working together across organisations, the team managed to coordinate a timely and appropriate response for this patient and prevented a hospital admission.

Growth and sustainability

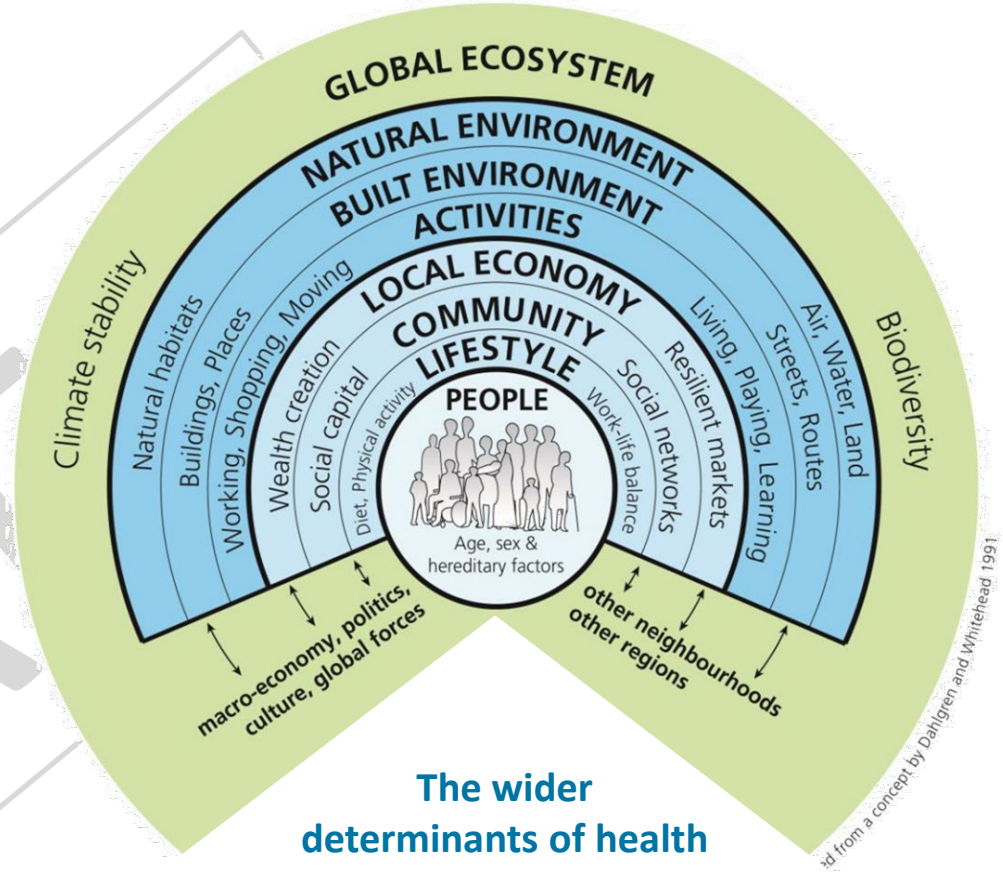
People are more likely to live happy, healthy lives if they have the best start in life, use their skills and have control over their lives. This includes access to good, fair employment, a healthy standard of living, with help to stop people getting ill, and access to sustainable places and communities.

Environmental sustainability: We aim to achieve net zero carbon emissions across the system by 2035, so we work in

- Moving towards a “circular economy” – reduce, reuse, repair, repurpose and recycle – with no waste.
- Building infrastructure (buildings, processes, transport) that helps us be sustainable.
- Making decisions with the future of our environment in mind.

Sustainable economic growth: Improving opportunities for prosperity for all our population, now and in the future.

- Making effective, efficient use of our public sector assets.
- Promoting investment in research and innovation.
- Increasing employment opportunities and support for local people to develop skills.
- Increasing investment in our economy, supporting people to work and shop locally, and businesses to invest here.



The wider determinants of health

Delivering social value: Making sure our work contributes to our whole society, so everyone has the chance of a decent standard of living.

- Keeping people healthy in their homes and communities
- Nurturing partnerships with anchor institutes, VCSEs and local employers to create are greater than the sum of their parts.

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

OUR APPROACH

How we will use our skills and resources differently to achieve our Goals

Our Workforce

Our health and care workforce are at the heart of our efforts to improve population health.

We need to have enough trained, engaged and valued staff. We want our workforce to represent our population, drawing people from all backgrounds.

To do this, we need to make sure that careers in health and social care are accessible, fair and equal, and support people with their own mental and physical health.

We need to innovate in the roles we offer, giving staff flexibility in their working lives, and embracing technology to work smarter and increasing innovation and research.

Our **one workforce** approach is based on solutions that enable staff to work across settings, and demonstrate positive outcomes for staff and residents.

Supporting our primary care staff

People working in primary care have been under increasing pressure. It can affect their own health and wellbeing.

In response, our Integrated Care Board wanted to help.

The result was the introduction of the ShinyMind app to help increase the resilience and reduce the stress of NHS staff.

Nine out of 10 staff report an improvement in wellbeing after using the programme, while seven out of 10 said their job satisfaction had improved.

Our leadership values:

Support to Provide Excellent Care, Every Time

Our **Clinical Services Strategy** will support and develop our clinical and professional teams to work at the top of their game to achieve the best health outcomes for residents.

A big part of this is learning from what we and others do. We will compare our care pathways with best practice and current evidence and adapt our approach accordingly. Getting feedback from patient, carer and staff feedback is also important. We will take part in innovation and research to find new and improved ways to support people.

In addition, we will:

- Embed ways of improving quality that allows health and care teams to provide excellent care, every time
- Involve patients, carers and staff in co-design and co-production of integrated health and care pathways based on residents' needs
- Work together to prevent ill-health and the causes of poor health, and maximise recovery after illness or injury.

Insert case study on resdesign of clinical care

Improving the Safety of our Care

Working together is vital, and especially when we are looking at quality issues with patient services.

The Patient Safety Incident Response Framework (PSIRF) is the new national way of improving patient safety in the NHS. It is for when we have problems in patient pathways that are in different health settings, or where the same problem happens across a number of health settings.

The frameworks sets out clear standards:

1. **Kindness and respect to the person affected and their family, with honesty about what happened**. We have seen cases in the NHS where people raised concerns which were not heard or addressed. We will always listen, respect and involve all people who raise a safety concern
2. **Support our staff, and address root causes of when things go wrong.** We do not support a 'blame culture' where staff are unfairly blamed for issues beyond their immediate control. We take responsibility for these contributing factors, and work with clinical teams to address them
3. **We will identify the major quality improvement programmes needed in instances where we haven't got care right**, and work together to make sure changes are sustained
4. **We will work on quality improvements along the whole health and care pathway**, working in partnership to improve patient experience and outcomes as they move between different health settings.

In our Integrated Care Partnership, we will use PSIRF to keep improving patient safety.

Managing our Money

Our health system has a budget of around £1.8 billion, managed by the Integrated Care Board.

We will work collectively to allocate and spend this money as efficiently as possible to deliver better health outcomes for our population. We will be working more closely between NHS, local councils and voluntary sector partners to make sure that funding is targeted to have the greatest impact.

Our place-based approach will help us to make the right decisions on local delivery of care to support our communities to thrive.

Comparing ourselves with the best

We need to compare ourselves against the best in the field so we can identify areas for improvement.

By setting these benchmarks, we will shorten patient clinical pathways by reducing unnecessary delays.

We will also review our clinical support and corporate services to ensure our teams have the tools and resources to offer the right care and treatment.

Giving people control of their care

People with Multiple Sclerosis and Epilepsy are being offered a different way to keep in contact with their health and care teams. This new service, called Patient Initiated Follow Up (PIFU), allows people to take control of their own care, and are reducing unnecessary visits to hospital and improving patient waiting times.

This service provides an alternative to a regular scheduled follow-up appointment, with calls answered on average in half a minute, and supports people to get access to help, ask questions about their medication, get test results and flag concerns with their symptoms without having to make an appointment with their GP.

One Public Estate

We recognise that the buildings and estate that we own, rent and occupy need to be used efficiently and effectively.

How we use our estates fundamentally changed since the pandemic.

The move to more preventative and personalised care outlined in this Strategy we change how we use our estate in the future.

Hybrid office working has meant that the amount of office space we need has reduced. Much more healthcare is now delivered on-line or in places other than hospitals.

The NHS and local Councils are reviewing how we use our estates to enable our teams to provide integrated care at Place.

How technology will join up and improve care

Our digital and data strategies set out how data and technology can help to deliver the best outcomes for our residents.

It means using information in a smarter way. A system-wide single shared health and care record will join up information to help provide seamless care. Patients can get easy access to their information. Technology can be used to support virtual wards and help patients to be cared for in their homes.

So that patients can…

- Spend less time at appointments and more with clinicians or caseworkers
- Not have to repeat their information more than once
- Have care informed by every touch point with the NHS or Local Authority
- Access information about past and future appointments, conditions, allergies, treatments, prescriptions, lab results and vaccinations
- Be more independent in activating and managing self-care

So that care practitioners can….

- Understand the whole patient, their lifestyle and health journey
- Access test results and scans quickly and easily
- Co-ordinate care with other professionals, wrapping around an individual
- Deliver high quality, safe care each and every time

So that people planning care can…

- See how residents are using care at any given moment, i.e. number of patients at A&E, number of patients on waiting lists for specific services
- Forecast demand based on previous trends and live data
- Predict future demand for high risk patients and provide pro-active care
- Intervene earlier to support better outcomes and reduce ‘reactive’ care
- Focus resources closer to the resident and around their individual needs

Understanding our Population's Needs

Good information is essential to plan, deliver and improve services and support residents to live longer, healthier lives.

We are working together to establish a single, shared data platform. This will ensure we have a consistent view of our data.

The platform will include anonymised information in areas such as performance, population health and inequalities, as well as capturing insights from residents.

This information will give us a rounded understanding to make decisions. It will support us to learn from best practice and tailor our activities to residents' needs.

We will share these insights across the system, working together to understand what it is telling us, and take decisions together.

We will publish our information as part of our commitment to accountability and benchmark our results against others to make improvements.

Using population health data to support better diagnosis and treatment

High blood pressure over a long period of time can increase the risk of heart attacks and strokes. Caught early, hypertension is easy to treat, but our current rates of detecting hypertension are much lower in some population groups.

GPs across Bedfordshire, Luton and Milton Keynes are working with pharmacies to building on a successful programme in Bedford Borough targeted to identify people who are at risk of hypertension but may not be coming forward for treatment.

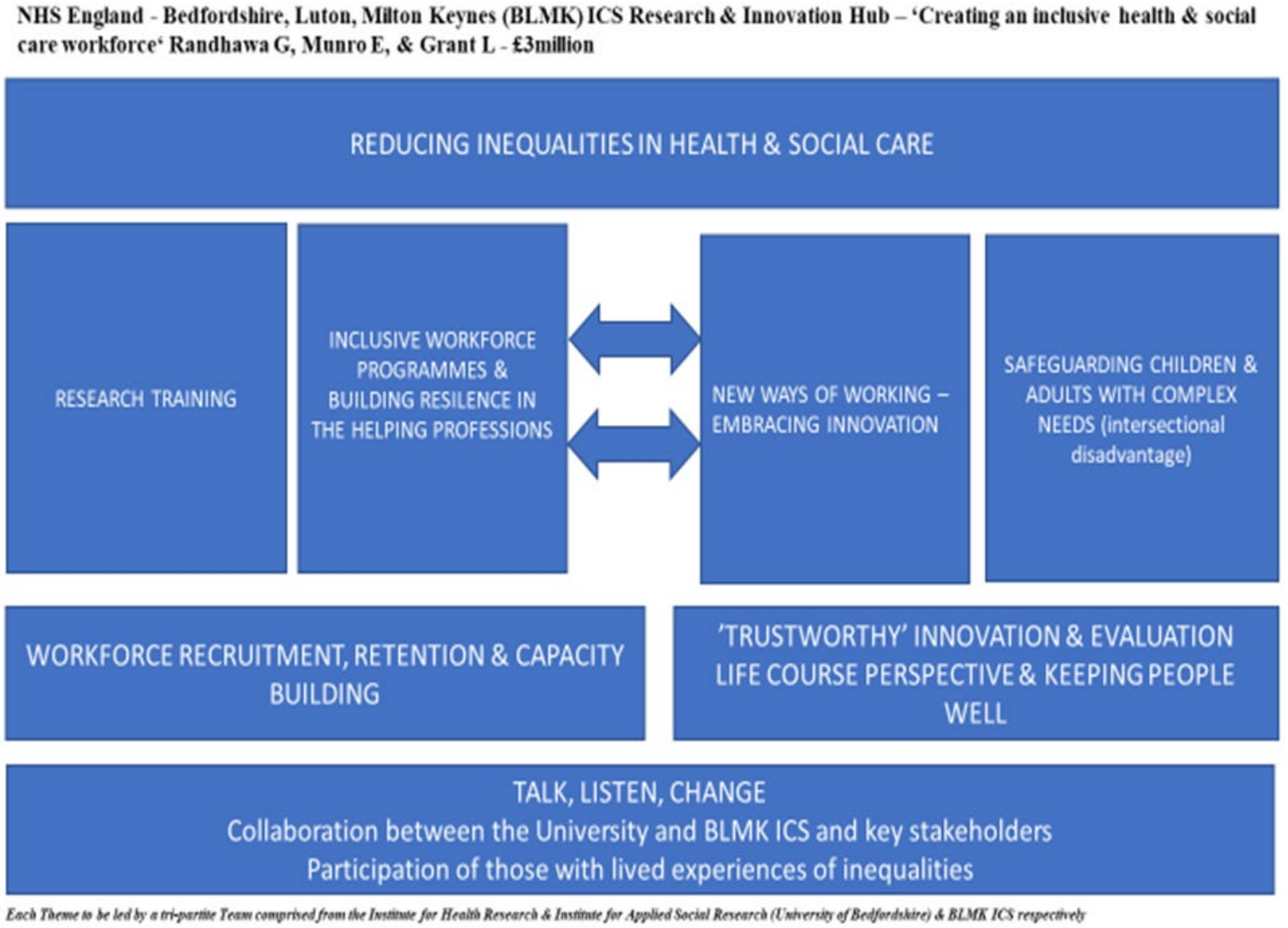
Research and Innovation

Promoting research to across our system

Our newly created Bedfordshire Research and Innovation Hub will focus on research into health and social care inequalities across our system.

By building research capacity and capability, this hub will aim to identify new ways of working to reduce inequalities. Two key priorities include how to develop an inclusive workforce and build resilience in the helping professions and how to safeguard children and adults with complex needs.

This hub will help act as a catalyst for further investment in health and care research across the system.



We are also working in partnership with Oxford and Eastern Academic Health Science Networks to implement, evaluate and spread innovations across our health and care system.

Working with People and Communities Committee - Annual Cycle of Business 2022/23

	Accountable Person (name on agenda)	Author/s	21/07/2022	07/10/2022 (16/09/2022 postponed)	16/12/2022	17/03/2023
Agenda Item Title	*<insert title of accountable Director and lead for paper>*	*<insert author/s>*	*<insert ✓where applicable>*	*<insert ✓where applicable>*	*<insert ✓where applicable>*	*<insert ✓where applicable>*
Opening Actions						
Welcome, Introductions and Apologies	Chair	Anona Hoyle	✓	✓	✓	✓
Relevant Persons Disclosure of Interests - Register of Interests	Chair	Governance	✓	✓	✓	✓
Approval of Minutes and Matters Arising	Chair	Anona Hoyle		✓	✓	✓
Review of Action Tracker	Chair	Anona Hoyle		✓	✓	✓
Strategy (amend/delete as required)						
Working with people and communities Strategy and Policy	Chief of System Assurance & Corporate Services	Michelle Summers	✓			
Working with people and communities stategy and implementation plan	Chief of System Assurance & Corporate Services	Michelle Summers		✓		
Memorandum of Understanding (MoU) between ICB, ICP and VCSE	Chief of System Assurance & Corporate Services	Sonal Mehta		✓		
Operational (amend/delete as required)						
Engagement plan for Integrated Care System Strategy	TBC	Hilary Tovey		✓		
Winter Plan	Chief of System Assurance & Corporate Services	Peter Gibson		✓		
Denny Review	Chief of System Assurance & Corporate Services	Michelle Summers		✓		
Statutory Engagement - service changes	Chief of System Assurance & Corporate Services	Sarah Frisby		✓		
System-wide Co-Production training	Chief of System Assurance & Corporate Services	Rachael Bickley			✓	
Resident Voice on BLMK ICB committees	Chief of System Assurance & Corporate Services	Maria Wogan			✓ **verbal update**	
Musculoskeletal (MSK) Service redesign and procurement	Head of Planned Care / Senior Commissioning Manager	Sarah Florey			✓	
Primary care same-day access	ASSOCIATE Director Primary care Commissioining & Trabsformation	Amanda Flowers			✓	✓
Update from ICB Board on Working with People and Communities Strategy	Chief of System Assurance & Corporate Services	Maria Wogan			✓ **verbal update**	

	Accountable Person (name on agenda)	Author/s	21/07/2022	07/10/2022 (16/09/2022 postponed)	16/12/2022	17/03/2023
Bedford Primary Care Hub (To note under AOB)		Sarah Frisby			✓ **AOB (to note)**	
Update on the strategy and the engagement on the joint forward plan/operational plan	Chief of System Assurance & Corporate Services	Sarah Frisby			✓ **verbal update**	
Governance (amend/delete as required)						
WWPAC Terms of Reference	Chief of System Assurance & Corporate Services	Governance	✓	✓		
3-month review of WWPAC Policy	Chief of System Assurance & Corporate Services	Sarah Frisby		propose defer to March 2023	✓ **verbal update**	
Working with People and Communities Committee sub-group - System-wide Engagement Collaborative	Chief of System Assurance & Corporate Services	Michelle Summers		✓		
Cycle of business for WWPAC committee	Chief of System Assurance & Corporate Services	TBC	✓	✓	✓	✓
Communications from the meeting	Chief of System Assurance & Corporate Services	-	✓	✓	✓	✓
Committee Effectiveness (see 'meeting effectivness Q's in tab below)	Chair and all Board Members	-	✓	✓	✓	✓
Closing Actions						
Any Other Business	Chair	-	✓	✓	✓	✓
Date and Time of Next Meeting	Chair	-	✓	✓	✓	✓
An Undetermined Date						
Guidance regarding engagement during pre-election period	Maria Wogan	Sarah Frisby				?
Cancer Services	Anne Brierley	Kathy Nelson				
Digital strategy	TBC	Mark Thomas				?
Work-plan - Embedding co-production plan	TBC	Hilary Tovey				
ELFT Mental health bed provision	Richard Fradgeley	TBC				
Talk Listen Change	Adam Divney	Lisa Huson / Marek Lubelski				
Engagement plan for revision of the Joint Forward Plan (2023/2024)	Anne Brierley /Maria Wogan	Hilary Tovey / Jackie Bowry				?