NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Meeting of the Integrated Care Board in PUBLIC

Date: 25 November 2022
Time: 10:00 – 13:00
Venue: Council Chamber, Luton Council, Town Hall, Luton LU1 2BQ

Agenda

No.	Agenda Item	Lead	Purpose	Time
Opening Actions				
1.	Welcome, Introductions and Apologies	Chair	-	10.00
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			
6.	Chair's Report (verbal)	Chair	Note	10.05
7.	Chief Executive Officer's Report	Chief Executive Officer	Note	10.10
Strategy				
8.	Working with People & Communities Strategy	Chief of System Assurance & Corporate Services	Approve	10.20

No.	Agenda Item	Lead	Purpose	Time
9.	Memorandum of Understanding with the Voluntary, Community & Social Enterprise Sector	Chief of System Assurance & Corporate Services	Approve	10.40
10.	Fuller Programme – Update	Chief Primary Care Officer	Note	10.50
11.	ICP Strategy and ICB Operational Delivery Planning Update	Chief Transformation Officer	Note and Approve	11.00
12.	Reports from Place Based Boards: • Bedford Borough • Central Bedfordshire • Luton • Milton Keynes	Local Authority Chief Executive Officers	Note	11.10
13.	Developing a BLMK Mental Health, Learning Disability & Autism Collaborative	Chief Strategy & Digital Officer, CNWL / Director of Integrated Care & Deputy CEO, ELFT	Approve	11.30
Refreshment break – 11.45 – 12.00				
Operational				
14.	East Kent Maternity Report	Chief Nursing Director	Note	12.00
15.	Quality and Performance Statement	Chief Nursing Director and Chief of System Assurance & Corporate Services	Note	12.05
16.	Finance Report September 2022 – Month 6	Chief Finance Officer	Note	12.15
Governance				
17.	Board Assurance Framework	Chief of System Assurance and Corporate Services	Note and Discuss	12.25
18.	Corporate Governance update: ▪ Changes to SORD and SFIs ▪ Business case process	Chief of System Assurance and Corporate	Approve and Note	12.30

No.	Agenda Item	Lead	Purpose	Time
	▪ Committee Chairs updates including Minutes	Services & Committee Chairs		
19.	Communications from the meeting	Chair	Discuss	12.40
20.	Annual Cycle of Business	Chair	Note	12.45
21.	Review of meeting effectiveness • Feedback requested on effectiveness of holding Board meetings in different places	Chair	Discuss	
22.	Questions from the Public	Chair		12.50
	Closing Actions			
23.	Any Other Business	Chair	-	12.55
24.	Date and time of next meeting: ▪ 27 January 2023 (10am) ▪ Council Chamber, Bedford Borough, Borough Hall, Cauldwell Street, Bedford, Beds MK42 9AP Deadline for papers will be: ▪ Noon, Monday 16 January 2023	Chair	-	

Resolution to exclude members of the press and public

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

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
Board of the Integrated Care Board Members
as at 14.11.22

				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**
Blakeman	Andrew	Non Executive Member	No	N	N	N	N	Director, STRYDE International Ltd, a subsidiary of BP plc, Chertsey Rd, Sunbury-on-Thames, TW16 7BP, and previous directorships within the BP Group	01/01/1996	Ongoing	This is not a conflict of interest and requires no mitigation. However, most COI registers require all directorships of private companies to be declared.	15/06/2022
Borrett	Alison	Non Executive Member	No									21/06/2022
Bracey	Michael	Chief Executive, Milton Keynes Council	No									11/05/2022
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
Carter	David	Chief Executive, Bedfordshire Hospitals Foundation Trust	Yes	Y				Chief Executive of Bedfordshire Hospitals NHS Foundation Trust	08/05/2017	Ongoing		18/05/2022
Carter	David	Chief Executive, Bedfordshire Hospitals Foundation Trust	Yes				Y	Wife employed by NHS England Eastern Region	11/07/1905	ongoing		18/05/2022
Cartwright	Sally	Public Health Representative, Luton	No									22/06/2022

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Church	Laura	Chief Executive, Bedford Borough Council	Yes	Y				Bedford Borough Council, Commissioner of Public Health and Social Care Functions	05/10/2021	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
Church	Laura	Chief Executive, Bedford Borough Council	Yes		Y			East of England Local Government Association - Chief Executive lead on health inequalities	01/12/2021	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
Church	Laura	Chief Executive, Bedford Borough Council	Yes				Y	Ian Turner (husband) provides consultancy services to businesses providing weighing and measuring equipment to the NHS	05/10/2021	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
Coiffait	Marcel	Chief Executive, Central Bedfordshire Council	Yes	Y				I am the Chief Executive of Central Bedfordshire Council which may be commissioned to work on behalf of the ICB	01/11/2020	Ongoing		27/05/2022
Cox	Felicity	Chief Executive	Yes		Y			I am a registered pharmacist with the GPC (General Pharmaceutical Council) and a member of the Royal Pharmaceutical Society	17/08/1987	Ongoing	I will excuse myself should an interest arise	14/06/2022
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	Regular 1-1s flag any issue and agenda items	27/09/2022
Graves	Stuart Ross	Chief Strategy & Digital Officer, Central & North West London Foundation Trust (Community/Mental Health &	No									20/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Interim Chair, University of Buckingham	01/04/2022	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Vice Chair NHS Employers Policy Board	13/07/1905	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Trustee of NHS Conferation	13/07/1905	Ongoing	Declare in line with conflicts of interest policy	16/05/2022

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Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Council Member - National Association of Primary Care	12/07/1905	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				Keele University - Lecturer	08/07/1905	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				Advisor to Alphasights, MM3 Global Research, Silverlight and Stepcare	10/07/1905	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Chair, CRN Thames Valley & South Midlands Partnership Group Meeting		Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Member, Oxford AHSN		Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes				Y	Spouse, Samantha Jones, is the Permanent Secretary and COO for No 10 Downing Street	01/03/2022	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Head	Vicky	Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes	No									27/06/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Director of Clinical Transformation, BLMK CCG	04/08/2020	44742	Role ended N/A	29/07/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			The Bridge PCN Clnical Director	01/04/2021	45016	Exclusion from direct decisions affecting PCNs	11/05/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Member, NHS Confederation Primary Care Network	07/07/2019	Current	Exclusion from direct decisions affecting PCNs	08/09/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Member, National Association of Primary Care (NAPC) Council	01/10/2020	Current	Exclusion from direct decisions affecting PCNs	08/09/2022

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Makarem	Rima	Chair	Yes		Y			Chair of Sue Ryder (non remunerated)	01/05/2021	Ongoing	Declare in line with conflicts of interest policy	17/06/2022
Makarem	Rima	Chair	Yes	Y				Chair of Queen Square Enterprises Ltd (remunerated)	01/11/2020	Ongoing	Declare in line with conflicts of interest policy	17/06/2022
Makarem	Rima	Chair	Yes	Y				Lay Member of General Pharmaceutical Council	Apr-19	Ongoing	Declare in line with conflicts of interest policy	17/06/2022
Mattis	Lorraine	Associate Non Executive Member	Yes	Y				Director - Community Dental Services CIC	01/11/2019	Ongoing	Declared in line with conflicts of interest policy	09/09/2022
Pointer	Shirley	Non-Executive Member, Chair Remuneration Committee	No									15/06/2022
Porter	Robin	Chief Executive, Luton Borough	No									17/05/2022
Poulain	Nicky	Chief Primary Care Officer	No									30/06/2022
Roberts	Martha	Interim Chief People Officer	No									04/07/2022
Shah	Mahesh	Partner Member	Yes	Y				AP Sampson Ltd t/a The Mall Pharmacy, Unit 3, 46-48 C	32448	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	41726	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	43193	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	44287	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

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Shah	Mahesh	Partner Member	Yes		Y			Community Pharmacy PCN Lead, Oasis PCN, Luton	43867	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related	20/05/2022
Stanley	Sarah	Chief Nurse Director	No									08/09/2022
Stock	Tracey	Chair, Health & Care Partnership					Y	Member of the East London Foundation Trust (ELFT) Council of Governors	15/12/2021	01/05/2023	None	05/07/2022
Taffetani	Maxine	Healthwatch Representative for Bedfordshire, Luton and Milton Keynes	No									22/06/2022
Westcott	Dean	Chief Financial Officer	Yes				Y	Wife is Senior Mental Health Transformation Manager at West Essex CCB	01/06/21 on joining CCG	Ongoing	Email 15/6/22 - "Should there be any Mental Health links with West Essex (unlikely)I would of course withdraw from any discussions/decision making	14/06/2022
Westcott	Dean	Chief Financial Officer	Yes		Y			Chair of Board of Trustees - Association of Chartered Certified Accountants Pension Scheme	01/06/2021 on joining CCG	Ongoing	Email 15/6/22 - "The Acca interest is completely outside of the NHS and will finish at the year end in any event"	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes				Y	Civil partner, Advanced Nurse Practitioner (Walnut Tree Health Centre, Milton Keynes)	2010	Ongoing	To be addressed as required	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes		Y			Stonedean, Practice - Former Partners and current sessional GP	39234	Ongoing	To be addressed as required	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes	Y				GMC (General Medical Council – Associate – Assessor medical performance	2012	Ongoing	To be addressed as required	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes	Y				AKESO (coaching network) – coach – Executive and Performance Coach	43862	Ongoing	To be addressed as required	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes	Y				NHSE – Appraiser (Summative & Formative discussions)	2010	Ongoing	To be addressed as required	14/06/2022
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes	Y				I am a Non-Executive Director and Deputy Chair of Northamptonshire Healthcare NHS Foundation Trust, St Mary's Hospital, London Road, Kettering NN15 7PW. NHFT provide prison health services to Yarlswood Immigration Removal Centre and Bedford Prison in BLMK. These services are not commissioned by BLMK ICB.	Nov-18	Ongoing	Exclusion from involvement in related meeting or d	14/07/2022
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes	Y				I am Chair of Trustees for Arts for Health MK a registered charity that is responsible for the art collection at MK University Hospital NHS Trust and provides art on prescription for MK residents. Address MK University Hospital, Standing Way, Eaglestone, Milton Keynes MK6 5LD	2010	30/09/2022	Will be declared as relevant in meetings and will not be involved in any funding or other decisions where Arts for Health MK may be a beneficiary. Standing down from role by 30/09/22.	14/07/2022

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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: 30 September 2022

Time: 10:00 – 13:10

Venue: Milton Keynes Council Chamber, Civic Offices,
1 Saxon Gate East, Central Milton Keynes MK9 3EJ

Minutes of the: Board of the Integrated Care Board in **PUBLIC**

Members in attendance:		
Alison Borrett	Non-Executive Member	AlBo
Michael Bracey	Partner Member, Local Authorities	MB
David Carter	Partner Member, NHS Trusts and Foundation Trusts	DC
Laura Church	Partner Member, Local Authorities	LC
Marcel Coiffait	Partner Member, Local Authorities	MC
Felicity Cox	Chief Executive Officer	FC
Manjeet Gill	Non-Executive Member	MG
Ross Graves	Partner Member, NHS Trusts and Foundation Trusts	RG
Dr Omotayo Kufeji	Partner Member, Primary Medical Services	OK
Dr Rima Makarem (Chair)	Chair	RM
Shirley Pointer	Non-Executive Member	SP
Robin Porter	Partner Member, Local Authorities	RP
Mahesh Shah	Partner Member, Primary Medical Services	MS
Sarah Stanley	Chief Nursing Officer	SS
Dean Westcott	Chief Finance Officer	DW
Dr Sarah Whiteman	Chief Medical Director	SW

Participants:		
Anne Brierley	Chief Transformation Officer	AnBr
Sally Cartwright	Interim Director of Public Health, Luton	SC
Vicky Head	Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes Councils	VH
Lorraine Mattis	Associate Non-Executive Member	LM
Nicky Poulain	Chief Primary Care Officer	NP
Martha Roberts	Chief People Officer	MR
Cllr Tracey Stock	Chair, Bedfordshire, Luton and Milton Keynes Health and Care Partnership	TS
Maxine Taffetani	Participant Member for Healthwatch within Bedfordshire, Luton and Milton Keynes	MT
Maria Wogan	Chief of System Assurance & Corporate Services	MW

In attendance:		
Nicky Barnes	Head of System & Estates (for item 10)	NB
Sarah Feal	Head of Governance	SF
Gaynor Flynn	Governance & Compliance Manager	GF
Anne Murray	Interim Chief Nursing Officer	AM
Mark Thomas	Chief Digital and Information Officer (for item 9)	MTo

Apologies:		
Andrew Blakeman	Non-Executive Member	AnBl
Joe Harrison	Partner Member, NHS Trusts and Foundation Trusts	JH

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed all to this Meeting of the Board of the Bedfordshire, Luton & Milton Keynes Integrated Care Board (ICB). Apologies were noted as above. The Chair welcomed Anne Brierley as the ICB's newly appointed Chief Transformation Officer, Sarah Stanley as the ICB's newly appointed Chief Nursing Officer and Manjeet Gill, who has joined the ICB as a Non-Executive Member. It was confirmed that the meeting was quorate. The meeting was recorded for the purpose of the minutes.	
2.	**Declarations of Interest – Register of Members' Interests** Members had reviewed the Register of Interests and confirmed that entries were accurate and up to date. 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. No conflicts of interest were declared in relation to matters on the agenda.	
3.	**Approval of Minutes and Matters Arising** The Board confirmed its agreement that the minutes were a full and accurate record of the meeting, subject to the following change: - Page 1 Cllr Tracey Stock to be added as an attending participant. **Action:** GF to add Cllr Tracey Stock as an attending participant in the minutes for the meeting held on 29.7.2022	GF

	There were no matters arising that did not form part of today's agenda.	
4.	**Review of Action Tracker** Actions closed: 5, 6, 10, 12, 13, 14, 17, 18, 19 20, 21, 22, 24 & 25 All other actions are 'work in progress' or 'not yet due'.	
5.	**Chair's Report** (Verbal) The Chair thanked Anne Murray and Richard Alsop for their roles as Clinical Commissioning Group Executive Directors and for covering ICB Executive roles to this point. We have one vacancy for the Board, Primary Medical Services Partner, which we hope to recruit to during the autumn. We recently launched our research Hub with University of Bedfordshire, which was attended by our newly appointed Innovation Manager jointly appointed by the ICB and the two AHSNs. The University has secured £3 million from the National Institute for Health & Care Research (NIHR) for the Research Hub and has raised a further £2million for areas of Public Health which are relevant to our agenda as an ICB. The Chair reported that she had delivered several presentations including one at Healthwatch Milton Keynes Annual General Meeting. She would be delivering presentations to new GPs, NHS partner organisation Non-Executives and Foundation Trust Governors, at Community Action Milton Keynes Annual General Meeting and at the Health Service Journal Conference as an invited panel speaker to talk about transformation. The Board **noted** the verbal report.	
6.	**Chief Executive's Report** Taking the report as read, the Chief Executive highlighted the following: This is the first Chief Executive's Report in this style and has been developed to provide updates in key areas, matters arising not covered on the agenda and updating the Board on other areas not being covered at the meeting. The report includes case studies which demonstrate integration. We would like to collect case studies from across the system to further demonstrate how integration is working for the people we serve. These can be in other reports from partners or can be emailed by partners to the ICB's Communications and Engagement Team using the email address in the report. They will help us to make sure we focus on the people we serve. **Action:** All partner organisations to share case studies to further demonstrate how integration is working for the people we serve. (can be in other reports from partners or can be emailed by partners to the ICB's Communications and Engagement Team blmkicb.communications@nhs.net)	All partner organisations

	An omission in the report was noted - the end of the first paragraph in Section 5 should read 'Arlesey Medical Centre located in Central Bedfordshire and Shortstown Surgery located in Bedford Borough'. The Board **noted** the report.	
7.	**System People and Workforce Report** The Chief People Officer (CPO) gave a brief overview of the report. We have a positive historical working relationship on system people in Bedfordshire, Luton & Milton Keynes. There is already a lot of work going on between health & care across the system as detailed in the Bitesize document, which members are asked to share with their organisation and encourage them to contact the CPO. **Action:** All partners to share the System People 'Bitesize' document with their organisations and encourage them to contact MR. The People Plan – recently refreshed and approved by the System People Board. It supports the ten ICS delivery items. Workforce Race Equality Standards – an NHS standard which is also being piloted in Local Government and will help to give a system level view of what we need to think about to address inequalities. The Board was asked to discuss what is important in the development of a People Strategy for Bedfordshire, Luton & Milton Keynes Integrated Care System. Key points from discussion: - Think about sharing people and an agreed open rotation policy. - Give staff the opportunity to move around the system to broaden their experience and help partners balance demand. - Need to undertake further work on how we are engaging with the private sector, particularly in care settings as the vast majority of the workforce are based in non-NHS and non-local authority settings. This will need to be a strong theme. - Extend connections with care home providers - Need to focus on communications and marketing out to our residents to give them the opportunity to fill posts and promote Bedfordshire, Luton & Milton Keynes as a place to work to those outside of our area. - Need good role models to go into schools to promote opportunities - school ambassadors. - Need to recognise there will be cross working with other areas. - Most NHS organisations are not offering work experience opportunities – each partner will need to look at introducing this. - University of Bedfordshire can offer more places, but there are minimal placements opportunities, this would need to be addressed. - Need to make connections with the voluntary sector, particularly with groups supporting people into education and employment.	All partner organisations

	Funding - MR noted that we receive funds from Health Education England for small pieces of work but would like to use the strategy to request the funds as a lump sum. The Board: **Noted** the positive progress of the People Board against national guidance and expectations for 21/22. **Noted** the People Plan which has been approved by the System People Board. **Noted** the Workforce Race Equality Standards update. **Supported** the development of a People Strategy for the ICS.	
8.	**Milton Keynes (MK) Together Health & Care Partnership – "MK Deal" update.** Michael Bracey (MB) introduced the report which proposes the roles and responsibilities to be taken on by the Milton Keynes Health & Care Partnership (MKHCP) on behalf of the ICB in 2022/23 and the resources which the ICB will make available to support delivery of those responsibilities. The 'deal' has received broad agreement from the Milton Keynes Joint Leadership Team and is presented today for feedback and if agreed will be presented to the Milton Keynes Health & Care Partnership for approval. Key points from discussion: - It provides a direction of travel and an important first step. Unlocking the resource both to be able to discharge some of the responsibilities but also to think about what comes next is really important. - The ICB Executive is looking at how we can flex our workforce to better support places and hope to have a report on that at the next board. - It is important to recognise that what is right for Milton Keynes may not be right for the other three places due to different operational and population contexts. - For our people we need to make sure we use evidence based practice around what creates high performing teams. - The Place Linked Director role in this is to make sure that ICB resources are supporting all the 'MK Deal' priorities and that we develop from there in terms of what we are doing at place. - Need to make sure this gives us the flexibility to be creative and actually do things differently, which is probably more important or equally as important as the transactional elements of the 'deal'. - The Bedfordshire Care Alliance approach is very similar to this in terms of focus on specific work programmes and the alignment of ICB resources to those work programmes. - Consideration needs to be given to the Bedfordshire element of the system and how that relates to the three places as there are activities that we need to deliver at that level. The Chair noted that she is going to consider how the Board receives updates from each place as well as the Bedfordshire Care Alliance. **Action:** RM & MW to consider how the Board receives updates from each place as well as the Bedfordshire Care Alliance.	RM & MW

	The Chair confirmed the Board's agreement of the plan noting MW support as the link director and there to help on a practical day to day basis. The Board **agreed** the proposed MK Deal' and the next steps set out in the paper.	
9.	**Digital Strategy** The Chief Digital and Information Officer presented the report. The Digital Strategy follows the Population Health Management Strategy and the Data Strategy which were approved last year. All three documents have been co-produced with partners. The Digital Strategy starts and ends at the resident with five key themes, A resident first approach - Digital as an enabler - Putting Data at the heart of decision making - Personalised Care - Supporting Collaboration and Innovation. All partners have been fully engaged and participated in the development of the strategy. As part of the What Good Looks Like Assessment, to prevent duplication the community and mental health providers (East London Foundation Trust, Central & North West London Foundation Trust and Cambridge Community Services Trust) were 'assessed' within their core Integrated Care System outside BLMK and were also fully part of the Bedfordshire, Luton & Milton Keynes coproduction. What good looks like - a national drive. We were challenged to assess ourselves against seven key themes focusing on how we deliver health and care within our area. We engaged with all four places to make sure we did this as a complete system. We want to learn from others so worked with another ICS to support this. There is a digital programme of work supporting every element of health and care across our system which amounts to about £11 million of deliverables over the next 12 months. Key points from discussion: - We need to be careful of the number of apps we are introducing and the pace at which we introduce new technology. - There is a need to factor in interoperability issues, particularly in maternity and wider primary care. - Input is needed from other providers and other professionals not mentioned in the strategy. - We are being tasked with developing Maternity Digital Plan – it is essential for the Digital Plan to link in with this. We have midwives using manual data tools to produce information which is time consuming and not their core clinical work. - We need to increase interoperability and reduce duplication so we end up with 'one version of the truth' in terms of data which professionals and patients can access. The board: **Approved** the Digital Strategy **Supported** What Good Looks Like as our 22-23 delivery plan.	

10.	**Estates Utilisation Review** The Head of System & ICB Estates presented the report which provides a summary of work which has commenced under the new ICB Capital & Estates Oversight Group to review the utilisation of the Bedfordshire, Luton & Milton Keynes estate, in preparation for a larger piece of work to update the ICB Estates/Infrastructure Strategy. Background context was provided: The last time we carried out a thorough baseline exercise of our estate and produced a comprehensive estate strategy was 2018, we did a light touch refresh in 2021. Since 2018 our clinical strategies have continued to significantly evolve making it the right time for us to take stock and align our estates strategy with our clinical strategies. It is likely that many ICBs are in the same position and NHS England are producing guidance, for which there is currently no time scale. We have established the Bedfordshire, Luton & Milton Keynes Capital and Estates Oversight Group, which brings together estates and finance leads across the system. We are developing metrics to support prioritisation of our capital pipeline and up-to-date information on all of our property across the ICB for all of our partners and considering how we can best review how that estates is being used to best support delivery of our clinical strategies. We ask the Board for their support in raising this work as a priority with our partners and with the estates teams within our partner organisations in committing to providing the information requested and taking part. Key points from discussion. - We have a mixed picture across our local authority places around their involvement in the Local Government Association (LGA) and the Cabinet Office Property Units One Public Estate Programme, but in each of our places we have forums that bring together wider partners, including police and fire this work can directly feedback into. - A lot of work has been going on at places through the One Public Estate, programme which we have been doing for a long period of time. LC commented that she would like to see a faster pace on resolving the £1 million potential efficiency from system estates, which is a loss of investment to the delivery of services to the public. - Need to make sure clinicians are involved when we are linking this to the clinical strategies. - MB commented that he would like to see more of the work done at place level and with an opportunistic approach rather than just strategic – this is going to be key to realising opportunities locally. NB advised that our current list of estates projects is long, and we are unlikely to be able to afford the full number of estate schemes in our estate strategy. There are some significant proposals that we will take through the oversight group which we will bring back to the board in due course.	

	The Board: **Noted** that a piece of work has commenced across the system to review the utilisation of the Bedfordshire, Luton & Milton Keynes Estate, with the aim of identifying efficiency gains. **Noted** that this work programme will require support and input from all partner organisations within the ICB and **noted** the request for a strong place focus to the efficiency work.	
11.	**Quality & Performance Statement** Anne Murray introduced the report which summarises key areas of quality and performance across the ICB. We acknowledge we have got further work to do around the focus and the report methodology including how we report on quality & performance risk issues. For future Quality and Performance Committee meetings, we plan to use the intelligence and information sharing from partners and service providers to take a deep dive approach, which we would like to bring back in a more focused way in our reports going forward. The System Quality Group is now well established which enables the sharing of intelligence and key risks of concern from all stakeholders and providers. We are holding a development session on 25 October to look at our urgent & emergency care system. We know there are challenges and concerns and want to explore what we know and what we can do to improve experience, safety and effectiveness. MW added: There is development work to do on how we report to the Board based on our operating principle of subsidiarity as an ICB. We need to report to the Board on strategic matters and provide assurance that the performance and quality system working at place is fulfilling its function. The Board has a Quality & Performance Committee to rely on for assurance purposes and we are looking to increase the non-executive membership of that committee. From a performance perspective the system is under a great deal of pressure recovering from Covid and the coming winter pressures. We will also be under a great deal of scrutiny nationally in terms of granularity of reporting on performance over winter. The system wide Performance and Delivery Group brings all partners together to manage reporting upwards in terms of NHS requirements. There is excellent work going on between the ambulance trusts, acute trusts and community providers to improve services for our residents and make sure people get care when they need it. What we need to provide to the Board is assurance of that working and focus on a smaller set of key metrics rather than all the metrics we currently collect and report. The Board:	

	Noted the areas of risk identified and work underway to support mitigation and improve delivery. **Noted** the development day for the System Quality Group and support relevant colleagues from partner organisation to attend this day. **Approved** the focused approach to the quality and performance report and note the ongoing development work on reporting for the Board, its committees and places.	
12.	**Finance Report (July 2022 - Month 4)** The Chief Finance Officer highlighted the following: • The year to date system deficit is £1.6 million, we are forecasting a break even at year end. • The £1.6 million deficit is due to the way in which the Elective Recovery Fund is being reported by one of our partners. We have received verbal guarantees from NHS England that if there is any underperformance on the elective recovery targets during the first half of the year, that money will not be clawed back. • To date we are £3.6 million behind our plan on the system efficiency targets but confident we will recover that in the remainder of the year. Our target is £56 million for the year. • The pressures that Trusts are facing mainly relate to agency and bank costs, driven by levels of emergency activity that we are witnessing - COVID staff sickness and the Elective Recovery Program. • The position for the ICB function year to date and forecast is break even and that includes the brought forward under-spend from quarter one as a Clinical Commissioning Group rolled forward into the ICB position. • The figures we have just produced for month five confirms the position remains largely unchanged, both in terms of year to date and forecasts. • Key financial position risks are: o The elective recovery fund for the second half of the year - we have not had confirmation that if we were to underperform that there wouldn't be a clawback of those funds. o COVID and winter pressures. o Inflationary pressures. • The biggest concern is developing the efficiency programmes for next year. The Treasury will not be reviewing the money they have already handed to the NHS for inflation. We are currently working through our medium term financial plan and will be using our best estimates. • Capital - we are forecasting the system to break even against our Capital Departmental Expenditure Limit (CDEL) target, all other capital programmes are forecast to balance, the system Finance Directors will be closely monitoring that position. Key points from discussion: - We have not seen any details regarding the implications of the Government's announcement that they are cutting the increase in National Insurance. - In March we submitted a deficit plan of circa £40 million, the two key drivers of the deficit were the ongoing impacts of COVID and inflation, particularly inflation as it related to energy. There was an additional £1.5 billion available to the NHS. As a system we received £22 million additional funding to cover our forecast for inflation at that point in time.	

	If inflation continues to rise it will present an additional risk for the system. - We are reasonably confident of a year-end break even position. The Board need to be aware that this year we probably have more non recurrent resources at our disposal than we will have in future years. - Treasury have asked all spending departments to look at their plans again and as a result allocations for next year may be delayed. That will not stop us from working on our medium term financial plan, but we will have to apply more assumptions than we would have wanted to and one of those will be inflation. It was suggested that as the current report only relates to NHS finances, to provide a system perspective, it would be helpful to have a sense of context by including an update from Local Authority Finance Directors to aid our understanding of system pressures and to support our collaborative work on efficiencies. **Action:** DW to include a paragraph from each Local Authority in future Finance Report to the Board. The Board: **Noted** the month 4 and forecast position for revenue and capital **Noted** the risks to the financial forecast	DW
13.	**Planning for Winter 2022-23** The Chief of System Assurance & Corporate Services (MW) presented the report and highlighted the requirement from NHS England for the Board to receive assurance that winter planning has been undertaken and been well managed across our system. Colleagues from across health and care have played a role in pulling the plan together and we received positive feedback from our regional colleagues on the quality of the plan. The report covers lots of initiatives that are underway led by providers and local authorities to prepare for a challenging winter. Key points from discussion: - There needs to be more emphasis on the impact of the mental health perfect week and mental health alternatives to Accident & Emergency to relieve pressures on ED. - The risk of staff absence due to flu and Covid and the impact of that on the ability to deliver the plan should have greater emphasis in our plan and monitoring. - VH commented that she would like to hear or see commitment from all partners to push the flu and Covid vaccination programme among health and social care staff (*please refer to Agenda item 18 - Communications from the meeting*). - Where we use terms like the 'ICB's Flow Team' it would be really useful to know the size of the people resource. When we evaluate what we are doing, we need to know how much resource we have working on things. MW added - one of the initiatives all systems were asked to consider was the North Bristol model on a comply or explain approach. We did an analysis of what we do in terms of managing flow and it showed our current protocols are delivering beyond what the North Bristol model provides for our residents.	

	The Board: **Noted** the programme of work underway to prepare for what will be an extremely challenging winter period. **Noted** the additional capacity and alternative pathways being put in place to address expected demand for acute care in particular. **Noted** the assurance process in place through the Performance & Delivery Group.	
14.	**Local Maternity and Neonatal System Equity & Equality 5-Year Action Plan** Anne Murray introduced the report and explained that the plan has been produced as a requirement for the Local Maternity System (LMS) to respond to the Equity and Equality Guidance for Local Maternity Systems, which came about as a response to a recent 'Mothers and Babies Reducing Risk: through Audit and Confidential Enquires' across UK (MBRRACE-UK) report about maternal perinatal mortality still showing considerable differences in outcomes for women and babies from Black, Asian, and Minority Ethnic groups and those living in the most deprived areas. The Covid pandemic highlighted the urgency to prevent and manage ill health in those who experience the greatest health inequalities. Our plan has been through the LMS Board and the Health Inequalities Board (HIB) where it received positive feedback and was approved. It is a requirement for the Board of the ICB to see the plan and sign it off prior to submission and publication on our website. The plan has been developed by inclusion of Heads of Midwifery, Director of Midwifery, Inclusion Leads, maternity voices, public health colleagues and our regional support. We have a Digital Midwife and there has been work done looking at our position around women who access services and also gaining qualitative information around their experiences. We will have governance through the LMS and will be asked to report progress to the HIB. Key points from discussion: - It is not a duplication of the inequalities work program around the core 20 + 5 but we want to align and this needs to be a core part of that work. There is a significant requirement for Maternity therefore the LMS Board lead, produce and drive the plan linking to the HIB. - There has been a real focus on gestational diabetes and tobacco control as a very important priority for the LMS. **Action:** AM/SS to contact SC to discuss a query she has in the plan regarding use of the term 'lower deprivation' – v – 'higher deprivation'. The Board **approved** the Action Plan for submission to NHS England and publication on the ICBs website.	AM/SS
15.	**NHS Bedfordshire, Luton & Milton Keynes Clinical Commissioning Group (CCG) Annual Report & Accounts 2021/22**	

	The Chief Executive introduced the report – as the ICB is the successor organisation of the CCG it is required to produce an Annual Report and Accounts for 2021/22 and Annual Report and Accounts for quarter 1 of 2022/23 (April to June 2022). The 2021/22 report was developed in accordance with guidance and reviewed by the CCGs Governing Body Members. The Chief Finance Officer added that the accounts had been submitted on time, have been audited by the ICB's External Auditors, received an unqualified audit opinion and confirmation of no significant weaknesses with regards to 'value for money arrangements'. The Board will be required to approve the Annual Report and Accounts for quarter 1 2022/23 (April to June 2022). The timeline for submission will be summer 2023 but we are currently waiting for confirmation of this and further information from NHS England. The Board **noted** the report.	
16.	**Corporate Governance Update** The Head of Governance asked the Board to approve the: • Appointments to committee membership since 29 July 2022. The Board **approved** these. • Required amendment to detailed schedule to operational / financial scheme of delegation - a minor operational amendment was requested regarding the process for issuing Single Tender Waivers. The Board **approved** this. • Revised Terms of Reference (TOR) for: o Working with People and Communities Committee, and o Primary Care Commissioning and Assurance Committee. The Board **approved** these The Board was also asked to note: • The required amendments to the ICBs Constitution - NHS England's legal team conducted a review of their model Constitution and identified several small amendments that need to be made which will be submitted to NHS England for formal approval. The Board **noted** these. • Committee minutes and Chairs updates - key highlights provided by the Committee Chairs from the meetings that have been held since the last Board meeting. The Board **noted** these.	
17.	**Annual Cycle of Business** The Chair asked all in attendance who have items they would like included to inform the ICB's Head of Governance.	

	Action: All to inform the Head of Governance if they have any items they would like included on the agenda for the next meeting or on the Annual Cycle of Business.	All
18.	**Communications from the meeting** The Chair proposed that the key points from the strategies presented and approved at the meeting today are communicated. All in attendance were asked if there was anything else, they felt should be communicated. MW highlighted VH's point about promoting Flu and Covid vaccinations across all partners and this was supported.	
19.	**Questions from the Public** One question was received from Cllr Victoria Harvey about support for the Voluntary, Community and Social Enterprise (VCSE) sector. The Chair outlined the question, and the Chief Primary Care Officer gave a verbal response noting that the full question and response will be made available on the ICBs public website. The full question and prepared response is attached to these minutes.	
20.	**Review of meeting effectiveness** The Chair raised the following question (*as noted on the agenda*): 'Was the quality of the papers sufficient to allow you to discharge your duties and the expectations of each paper?' Responses: - Quality of papers much better than previous Board papers. - Executive summaries very helpful. - Need to refine/standardise our approach to the presentation of reports– what we are being asked to do from the outset and the context. - Many good discussions today. - 308 pages too much to read for a 2.5 hour meeting - difficult to pick out the relevant information. - Summary should include key information followed by slides or links for further reading. - Grateful to have received Meeting Pack on time. - Would like to see a resource section on the report front sheet which covers how many people in the ICB are working on the initiative/subject area. - Would be useful to know the governance route of some of the items so we know where debates have taken place prior to the item coming to the Board. - Would like to see the slides used today in the Digital Strategy Report used as a template for future strategy reports. **Action:** The Head of Governance to use the Digital Strategy Report power point slides to create a template for future strategies being presented to the Board.	SF

	Action: The Head of Governance to amend the reporting template so the resources and previous reporting routes are captured. The benefits of implementing a Board Management System/App was discussed and supported: - will provide an area for main reports and a reading room for additional reading for interest - users will be able to annotate as they read - will make papers much easier to navigate - the Meeting Pack will still be available as a PDF	SF
21.	**Any Other Business** No items received.	
22.	**Date and Time of Next Meeting:** 10:00 – 16:00 (exact time to be confirmed), Friday 25 November 2022 Luton Council, Council Chamber, Town Hall, Luton LU1 2BQ Deadline for reports will be noon on Tuesday 15 November 2022	

Approval of Minutes:		
Name	Role	Date
Rima Makarem	Chair	9/11/22

APPENDIX - Question from Member of the Public

Question:

My question is to ask the Integrated Care Board to increase the funding for prevention rather than funding being concentrated on GPs and Hospitals with the aim of an overall reduction in cost to the ICS.

Although social prescribing is funded, which is good, there is no funding for the actual activities usually run by community voluntary groups that social prescribers refer their patients to. These community groups struggle for funding and often small sums such a couple of hundred pounds can make all the difference to a groups survival. We are at risk of many preventative occupations of exercise, outdoor activity, arts, dance, social connectiveness etc being be lost as community groups cannot survive without funding and close down.

The work All-Party Parliamentary Group on Arts, Health and Wellbeing in their report "Creative Health: The Arts for Health and Wellbeing" showed that an Arts on Prescription project has shown a 37% drop in GP consultation rates and a 27% reduction in hospital admissions. This represents a saving of £216 per patient. A social return on investment of between £4 and £11 has been calculated for every £1 invested in arts on prescription. The benefits of walking and exercise to heart conditions and diabetes surely do not need to be explained to this board.

My request is for the ICS Board to look at different models which would help to fund the community groups such as the very successful Community Prescribing that took place in Newham in London for diabetes. One of the architects of Community Prescribing who was vice chair of Newham CCG has offered to talk to you about the details of Community Prescribing.

Two key examples;
I am particularly concerned about two groups in Leighton Buzzard which exemplify the problem

Walk 4Health is run by volunteers. There are three walks per week; one of half an hour, one 60 mins and one 90 mins. The walk is always followed by a time for coffee and tea and chatting and the social side is hugely important. The half hour walk is especially important at helping people with chronic conditions. The commitment by volunteers is significant as it is a two day a week commitment; one day for the walk and also one preparatory day checking the route in advance. However the volunteers as well as this commitment have to pay to print their own leaflets to promote the service to the surgeries. They also have to pay for their own travel expenses to travel to Bedford for training. It is really important that there are enough trained leaders so that the volunteer leaders are able to go away on holiday or fulfil other commitments. Small things like a fund for those who cannot afford walking shoes and perhaps a minibus trip up to Rushemere country park so that there can sometimes be a change of scene could really help the group. Lack of small sums of funding could end this fantastic service.

Spectrum Arts in Leighton Buzzard works with a huge range of people with a wide range of physical and mental disabilities and conditions on dance and performance which helps self esteem and overall health and engagement and general well being. It is very moving seeing people who are very disconnected from those around begin to engage, move and above all smile and look happy. This organisation uses many volunteers in its work but is at risk of closing due to lack of funding.

Leighton Buzzard abounds with Community Group that can offer a range of arts, walking, movement, knit and natter etc yet the lack of small amounts of funding prevent these groups from playing a significant role in reducing the pressure on GPs and hospitals.

Would the ICS please consider Leighton Buzzard being a pilot project for funding of community groups to reduce the pressure on GPs and Hospitals?

Response:

Helping people to stay well for longer is one of our key objectives in the Integrated Care Board (ICB) and we are working as system partners for a more ambitious and joined-up approach to prevention. Currently, Primary Care (including GP practices, community pharmacists, optometrist and dentists) all have prevention as a vital elements of their contracted work.

The ICB's prevention programme is a key recommendations of the 'Fuller Report' and the Chief Primary Care Officer is working with the Directors of Public Health in Bedfordshire, Luton & Milton Keynes, to develop the step-change approach on preventative care by:

- Supporting lifestyle change via a combination of national and local programmes providing advice and support to improve diet, fitness and wellbeing, e.g., health coaches and capitalising on evidence-based health apps, and the NHS app. This involves the extended primary care team, harnessing the growing role of community pharmacy and dentistry in prevention, VCS, and working at scale on prevention with local authority Public Health colleagues.
- A scaled approach to delivering population-level interventions, including screening and health checks, and adult vaccinations, building on the community engagement that was successfully established through the Covid-19 vaccination programme.

The 'Place Boards' are the forums where different models of care would be considered as part of local 'prevention plans'. Collaborative and integrated working within local communities at a place level is currently taking place with facilitation from Alexia Stenning (Associate Director of Primary Care, ICB) Elizabeth Elliott (Luton Borough Council, Public Health) and Marimba Carr (Bedford Borough, Central Beds and Milton Keynes Public Health Team) as system members.

We fully support your request to look at different models and would welcome the offer to hear about work from Newham about the details of Community Prescribing.

The ICB is committed to formalising a strategic partnership with the Voluntary, Community and Social Enterprise (VCSE) sector, building on existing structures and engagement at neighbourhood, place and system. The imbalance of funding with social prescribing models is recognised and the risk of community groups closing this winter due to their financial position is concerning, especially where they provide support to those more likely to experience health inequalities. There are mechanisms for the VCSE sector be engaged in place based discussions and in the short term, there will be opportunities to access funding to deliver activities that support preventative programmes at place.

In the longer term, having the VCSE sector as an equal strategic partner will ensure that we are able to realise our ambition of supporting local people to live longer in good health. The VCSE have an important role to play in service delivery but their insight and deep connections with local communities also means they have a central role in prevention. Community development approaches are an important element of social prescribing models that deliver better outcomes. Connected and active communities keep

people well and reduce pressure on traditional health services, and the ICB recognises its role in supporting a thriving VCSE sector.

Integrated Care Board - Action Tracker as at 11.11.22

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

Action No.	Meeting Date	Agenda Item	Action	Action Owner	Current Deadline	Current Position (Latest Update)	RAG
7	29/07/2022	Peer Accountability	To take forward peer accountability across the system at System Oversight Assurance Group and CEO Groups	Felicity Cox	31/03/2023	**17/8/2022:** Individual discussions being held with each CEO and then discussion at CEO Forum in October. Approach will be tested and refined throughout the year. Next discussion at SOAG meeting in December.	**Not Yet Due**
8	29/07/2022	Resident's Story	To take forward for next meeting and propose resident's story / item to be tabled later in agenda	Maria Wogan & Kim Atkin	25/11/2022	**11/11/2022:** Following a discussion at the Working With People and Communities Committee we will seek to link Resident's stories to agenda items and identify stories that relate to system working. For the November meeting we will have a Resident Story on co-production as an introduction to our discussion of the Working with People and Communities Committee.	**COMPLETE: Propose closure at 25.11.22 meeting**
9	29/07/2022	ICB Strategy	To prepopulate the strategy from existing work and to consider adding the word "happier" to our mission statement	Anne Brierley	27/01/2023	**11/11/2022:** There is an update on the development of the strategy on the agenda. The strategy will be presented to the Health and Care Pratnership on 14 December 2022.	**Not Yet Due**
11	29/07/2022	Place Strategies	To reflect Place strategies in Intgrated Care System Strategy review	Anne Brierley	27/01/2023	**11/11/2022:** There is an update on the development of the strategy on the agenda. The strategy will be presented to the Health and Care Pratnership on 14 December 2022.	**Not Yet Due**
15	29/07/2022	Public comms - access	Plan immediate action in terms of priority comms to the public regarding access to services, following Fuller Stocktake	Maria Wogan & Nicky Poulain	25/11/2022	**25/11/2022 meeting:** A leaflet has been designed which contains information about Primary Care. This is editable by practice. It is currently with Amanda Flowers for approval. An update to the Help Us Help You leaflet is also in design - to include the warm spaces and information on foodbanks and funding options for prescriptions - to help residens who are experiencing difficulty, as a result of the cost of living crisis.	**In Progress**
16	29/07/2022	Fuller Stocktake	To bring an update in terms of implementation following Fuller Stocktake, to the Board on a quarterly basis	Nicky Poulain	25/11/2022	**9/11/2022**: On agenda for 25/11/22 board and also on Annual Cycle of Business for quarterly updates.	**COMPLETE: Propose closure at 25.11.22 meeting**
23	29/07/2022	People Plan and Strategy	To bring revised People Plan & Strategy to the September meeting.	Martha Roberts	27/01/2023	**11/11/2022:** People Strategy to be presented to the Board on 27 January 2022.	**Not Yet Due**

Action No.	Meeting Date	Agenda Item	Action	Action Owner	Current Deadline	Current Position (Latest Update)	RAG
25	30/09/2022	Chief Executive's Report	Action: All partner organisations to share case studies to further demonstrate how integration is working for the people we serve. (can be in other reports from partners or can be emailed by partners to the ICBs Communications and Engagement Team blmkicb.communications@nhs.net)	All partner organisations	25/11/2022	**11/11/2022:** Case studies are being collected as part of the Moments that Matter campaign. Propose this item closes.	**COMPLETE: Propose closure at 25.11.22 meeting**
26	30/09/2022	System People and Workforce Report	Action: All partners to share the System People 'Bitesize' document with their organisations and encourage them to contact with MR (the ICBs Chief People Officer)	All partner organisations	25/11/2022	**9/11/2022:** MR confirmed that all the system partners are involved in the People Board which creates the Bitesize. Nothing has been specifically following mention at the Board of 30/9.	**COMPLETE: Propose closure at 25.11.22 meeting**
27	30/09/2022	Milton Keynes (MK) Together Health & Care Partnership – "MK Deal" update.	Action: RM & MW to consider how the Board receives updates from each place as well as the Bedfordshire Care Alliance.	Rima Makarem & Maria Wogan	25/11/2022	**26/10/22:** This is now a standing item in the Strategy section.	**COMPLETE: Propose closure at 25.11.22 meeting**
28	30/09/2022	Finance Report	Action: DW to include a paragraph from each Local Authority in future Finance Report to the Board.	Dean Westcott	25/11/2022	**1/11/22:** This request has gone to the Local Authority FDs to faciitate inclusion for the 14/11 paper deadline	**In Progress**
29	30/09/2022	Local Maternity and Neonatal System Equity & Equality 5-Year Action Plan	Action: AM/SS to contact SC to discuss a query she has in the plan regarding use of the term 'lower deprivation' – v – 'higher deprivation'.	Sarah Stanley	25/11/2022	**31/10/222:** SC and AM have had a conversation and are happy with meaning and understanding of the report.	**COMPLETE: Propose closure at 25.11.22 meeting**
30	30/09/2022	Annual Cycle of Business	Action: All to inform the Head of Governance if they have any items they would like included on the agenda for the next meeting or on the Annual Cycle of Business	All	25/11/2022	**11/11/2022:** Any requests for agenda items should be sent to: blmkicb.corporatesec@nhs.net	**COMPLETE: Propose closure at 25.11.22 meeting**
31	30/09/2022	Review of meeting effectiveness	Action: SF to use the Digital Strategy Report power point slides to create a template for future strategies being presented to the Board.	Sarah Feal	27/01/2023	**11/11/2022**: Working with People and Communities Strategy has followed the approach of the digital strategy.	**Not Yet Due**
32	30/09/2022	Review of meeting effectiveness	Action: SF to amend the reporting template so the resources and previous reporting routes are captured.	Sarah Feal	25/11/2022	**9/11/2022:** an updated reporting template has been agreed and these points have been included. The new template has been circulated to all Secretariat for the Committees and is avalable on the intranet.	**COMPLETE: Propose closure at 25.11.22 meeting**

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

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

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

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

Report Author	Felicity Cox Chief Executive Officer
Date to which the information this report is based on was accurate	14 November 2022
Senior Responsible Owner	Felicity Cox Chief Executive Officer

The following individuals were consulted and involved in the development of this report:
Maria Wogan, Chief of System Assurance & Corporate Services Anne Brierley, Chief Transformation Officer Michelle Summers, Associate Director, Communications and Engagement Rebecca Green, Deputy Programme Director ICS Establishment Sandra Vanreyk, Senior Programme Manager
This report has been presented to the following board/committee/group:

N/A

Purpose of this report - what are members being asked to do?
The members are asked to **note** the report.

Executive Summary Report

1. Brief background / introduction:

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

2. Summary of key points:

2.1 Case Studies on how we are working together to deliver improved health and care: 'Moments that Matter'

The work of the ICB team continues with partners to develop a bank of case studies to show how the system is improving outcomes for local people. The 'Moments that Matter' campaign started in October and is showcasing the work of partners. The case studies are being used in presentations, on social media, in the monthly stakeholder newsletter (Live Well BLMK and with regional and local media and broadcasters.

The case studies are available on the website www.blmkhealthandcarepartnership.org for partners to use, and they will be saved into NHS Futures, together with speaker notes to help those who want to share good news stories at events.

The case studies cover a range of areas from social prescribing to how funding is being used to increase service provision and how we're working to prevent poor health.

Working in partnership across a larger geography helps to attract national funding to support the **health and wellbeing of vulnerable people in communities in our area. By securing funding through NHS Charities Together, we have supported:**

- **Bedfordshire Rural Communities Charity:** This project has provided digital skills training and electronic devices to isolated people across Bedford and Central Bedfordshire. This improves their social wellbeing and helps to ensure that patients have equal access to digital health and social care services;
- **British Red Cross:** The 'Home Safe' Programme provides an improved discharge services for patients leaving hospital across Bedfordshire and Luton. The programme involves wellbeing check-ups during the discharge process to help prevent re-admission, which relieves pressure on hospital beds throughout winter when they are in high demand. The funding supported the recruitment of staff, volunteers and hired projects;
- **YMCA MK Hospital Navigator Scheme:** supporting people who attend hospital with injuries from domestic abuse and serious violence. Thirteen young people are currently being helped by this scheme in Milton Keynes; and
- **Community First Responder scheme:** Community First Responders are currently operational in Milton Keynes as a result of equipment and training that was provided by funding achieved by the ICS. The first responders are able to support the ambulance service by responding to life threatening calls in the community and in care homes and supporting, until the ambulance arrives.

This is a great example of how NHS organisations, local authorities, voluntary groups and charities can work together to make a positive difference to the lives of people in our communities. There is draft Memorandum of Understanding with the voluntary, community and social enterprise (VCSE) sector on the Board agenda for November which will enable us to build a sustainable model for working with the VCSE going forward.

Other case studies in development include:

- ICB funding for key workers for young people with learning disabilities, so they can get the support they need to reach their full potential; and
  Social prescribing initiatives for people and families that can transform their lives by tackling social isolation, depression and anxiety.

The campaign will continue over the coming months and partners are requested to share case studies with the communications and engagement team blmkicb.communications@nhs.net so that we can make sure we share the good work that our teams are doing to improve the health and wellbeing of people and communities in our area.

2.2 100 Day Plan update and closedown

In September we shared an update on progress against delivery of the 100 Day Plan for the Integrated Care Board. I am pleased to further update the Board that we passed the 100 day milestone on 8 October and have successfully concluded this process which focused on the establishment of the new organisation, on-boarding of staff and the Board, and new ways of working.

All deliverables within the 100 Day Plan presented at the ICB first Board meeting on 1 July 2022 have been achieved and we will continue to build on this progress through the wider Organisational Development work led by Martha Roberts, Chief People Officer.

2.3 Head and neck cancer services

Milton Keynes University Hospital NHS Foundation Trust (MKUH) have proposed a hub and spoke model with Oxford University Hospitals NHS Foundation Trust (OUH) for head and neck cancer services. This has been prompted primarily by the long waiting times and associated issues with the current specialised service provider (Northampton General Hospital NHS Trust). Specialised Commissioning Teams from NHS East of England, South East and Midlands are working together to ensure that the suggested changes will meet patient needs and the defined requirements for such a service. In principle, the Cancer Alliances, Providers and BLMK Health and Care Senate are supportive of the new model. The Board will be kept informed of progress on this matter.

2.4 Research and Innovation Hub launch

Together with NHS England, the ICB has provided £3million funding to the University of Bedfordshire to establish a Research and Innovation Hub, which will see academics and researchers from the University's Institute for Health Research (IHR) and Institute of Applied Social Research (IASR) join forces with local health and social care professionals to work on a number of targeted projects over the next three years to advance health and care processes, support services and service-user outcomes.

The Hub's focus in the first year has been established under four priority 'pillars':

1) inclusive workforce;
2) new ways of working; and
3) safeguarding.

4. Research Training/Development (under development)

Confirmed projects for each pillar include:

- **Inclusive Workforce Pillar**
  - *'Community Targeted Outreach Programme: Intervention and evaluation'* – overseen Dr Nasreen Ali & Martha Roberts
  - *'Building resilience in the Caring Professions'* – overseen by Dr Lisa Bostock
- **New Ways of Working Pillar**
  - *'Ageing well: Frailty & Sarcopenia Screening and Intervention Study'* – overseen by Professor David Hewson and Nicky Poulain
  - *'Primary care access: Improving access to primary care for older people, minority ethnic communities and disadvantaged communities across BLMK'* – overseen by Dr Erica Cook, Professor Gurch Randhawa, Dr Yannis Pappas and
  - Dr Chirag Bakhai
- **Safeguarding Pillar**
  - *'Reducing harm from "street activities" through collaboration and dialogue'* – overseen by Dr Sarah Wadd, with additional funding from Luton Council for a mapping study

This level of innovation will ensure that the ICS prioritises and delivers innovations in health and care, which will help to achieve our ambition to help people and communities live longer in good health.

2.5 Specialised Commissioning Update

a. The initial submission from all East of England Integrated Care Systems on the readiness for specialised commissioning delegation has been completed with a collective recommendation to run in shadow form during 2022/2023- 2023/24 (Joint Committee with NHSE) and will be formally submitted at the end of November.
b. This would give the East of England Integrated Care Systems a year to:
   i. Complete the delegation readiness outlined in the national NHSE document 'Roadmap for integrating specialised services within Integrated Care Systems';
   ii. Conduct our own due diligence on the scope and risk, including changes such as the move to population-capitated funding (expected to increase specialised commissioning funding into the East of England region) ;
   iii. Agree with all the East of England ICBs the initial transformation programme for a very small number of specialist services provision, based on current access, health outcomes, and local population need; and
   iv. Agree with NHSE and the East of England ICBs the staffing and governance to support this transition and ongoing assurance.
c. BLMK ICB CEO has agreed with the East of England ICB CEOs, that each attend the next meeting in late November with a shortlist of circa 4-5 issues that need resolution along primary to tertiary existing pathways and 1-2 proposals for transformational re-design within the specialised commissioning national service specifications. The Board will be kept informed with progress with this work.

2.6 Efficiencies and Transformation Board Update

a. At the ICB Board in July, it was agreed that we would take a pan-system approach to driving out avoidable costs to address the expected financial shortfall for 2023/2024
b. The Chief Transformation Officer and the Chief Finance Officer have met with system Chief Finance Officers to agree the core principles for framing and delivery of this, and how they align with the financial principles previously agreed by the Chief Finance Officers
c. The re-launched process will start in December, with a focus on the 'big ticket' items and comparison of our current delivery / spend against the 'best in class' models to determine the size of the opportunity, with delivery determined and owned with Place / collaborative and ICB

d. We will triangulate the work programme with the 'must-dos' (such as pathology network) and highest pressures / risks in the system (such as supported discharge from acutes) to ensure we drive the best quality and operational outcomes from this work as well as cost pressures reduction (and do not cause unintended consequences to delivery)
e. The meeting will be short and focused, and have a split agenda to ensure the right people are round the table:
    i. Week 1 – strategic priorities 1-4, for example complex care placements; and
    ii. Week 3 – strategic priority 5 and corporate functions, such as centralise contracting to drive value from suppliers
f. Trust CEOs have been asked to confirm their core members for this group by **2 December.**

2.7 Consultation on changes to the provider licence

NHSE has issued a consultation document on changes to the provider licence which takes into account the creation of Integrated Care Boards. For BLMK our next step is to develop our internal 'peer accountability' arrangements that will support us to work together to address performance challenges. We plan to discuss this at the next System Oversight and Assurance Group meeting on 13th December 2022 and will report back on the outcome of this meeting to the next Board meeting.

Link to the consultation document: https://www.engage.england.nhs.uk/consultation/nhs-enforcement-guidance

2.8. Board development session - 4 November 2022

We held our third Board development session on 4 November at Priory House. Feedback on the session has been very positive from Board members and the topics covered were:

- reflections on how we are working as a system to deliver longer, healthier lives for our residents
- developing the integrated care strategy for our residents, building up from places and collaboratives
- tackling our wicked issues and system risks with a deep dive on the workforce risk
- our future target operating model

All of these discussions will be taken forward in our strategy development work and there is a paper updating on progress with this elsewhere on the Board agenda. Outputs from the risk discussion have also fed into the updated Board Assurance Framework on the Board agenda and will contribute to the development of the People Strategy which is due at the Board meeting in January. Thank you to Board colleagues for their preparation for the session and participation on the day.

2.9. Senior Leadership Group meeting - 14 November 2022

On Monday 14 November, we held a development session for the ICB's Senior Leadership Group. This session focused on our roles as leaders in implementing new ways of working as an ICB including the way in which we will organise our teams to provide support to delivering work at place and through collaboratives as part of evolving our target operating model, based on the principle of subsidiarity. Colleagues were very supportive of the direction of travel and enthusiastic about the opportunities to work collaboratively across the system with a wide range of partners to deliver improved outcomes for our residents. We will continue this development programme to support and engage with our senior leaders as we re-shape our organisation around our system priorities and new ways of working as an ICB.

2.10. Key events October and November

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

5th October	BLMK ICS Inequalities Event This was a productive event with good representation from across the system. We look forward to seeing the outputs.
13th October	NHS National Leadership Event The system was represented by Joe Harrison and Paul Calaminus, where they facilitated a discussion on practical improvement examples on workforce retention.
20th October	ELFT Staff Awards Ceremony This event was an inspirational night. One of the award winners a service user/staff member from vaccination hesitancy project will be invited to present at a future ICB staff briefing to showcase their work.
25th October	Leavale Medical Centre, Luton The CEO, Sarah Stanley and Dr Sarah Whiteman were invited to visit the practice where the afternoon's events were facilitated by Dr Nina Pearson, Strategic Clinical Lead Primary Care Workforce for BLMK and GP Partner, Lea Vale Medical Group. After meeting members of the team, Dr Pearson took led a tour of the immediate locality where colleagues learned more about 'deep end' practices, whose patients are from the most deprived areas of the country. A visited is being organised for the Chair and NEMs.
31st October	Clare Panniker, NHS East of England Regional Director, visited BLMK The CEO and Executive Team welcomed Clare Panniker on her first visit to BLMK and at a 'meet the ICB team' session. The team had the opportunity to showcase some key pieces of work, with colleagues from across the ICB, including retention in general practice, improving cancer outcomes, research and innovation, taking the ICB forward and how we will improve flow. The Executive Team also talked about the key issues in our system and how region can support us. The second part of the visit was a visit to North Wing in Bedford to look at the capital programme, where she was joined by the CEO, Laura Church, the Mayor of Bedford, Dave Hodgson, and Nikki Barnes, Associate Director for Estates.
10th November	Luton Town Centre Stakeholder Group This was a thought-provoking evening and I made connections to colleagues from the ICB to prompt further discussion about what can be done to support the work of this group.
11th November	Luton Community Awards A great celebration of the community, an insight into the fantastic work being done at place and great to see how local GPs are leading some of the community initiatives.

Key events coming up include:

- The Leadership Role of all NHS Chairs and CEOs in Tackling Inequalities, organised by the NHS Ethnic Minority Chairs and CEO Network;
- ICS Network Conference;

- Royal Pharmaceutical Society Advisory Group, final meeting on the Vision for Pharmacy Practice;
- Finance Away Day – the Finance teams from the ICB, Bedfordshire Hospitals Foundation Trust and Milton Keynes University Hospital Foundation Trust will be meeting for the first time as a collective group; and
- Also looking forward to upcoming Carol Concerts in December, where I will be representing the ICB.

2.11 Recently published ICB guidance

Since the last Board meeting on 30 September 2022, NHS England have published updated guidance for Integrated Care Systems. Key guidance for the Board to note includes:

- **Emergency Preparedness, Resilience and Response Annual Assurance Guidance**
  NHS England » Emergency preparedness, resilience and response: annual assurance
- **Operating Framework for NHS England**
  NHS England » NHS England operating framework
- **Roadmap for integrating specialised services within Integrated Care Systems**
  PAR1440-specialised-commissioning-roadmap-addendum-may-2022.pdf (england.nhs.uk)
- **System Workforce Improvement Model (SWIM): A support tool for ICSs**

3. Are there any options?

Not applicable.

4. Key Risks and Issues

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

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

Not in relation to this report but are reported and managed through the specific pieces of work and the corresponding governance.

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

None

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

Click to view Green Plan

Not applicable

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

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

8. Next steps:

As described in the report.

9. Appendices

None

10. Background reading

None

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
8. Working with People and Communities Strategy

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

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

Report Author	Michelle Summers Associate Director Communications and Engagement
Date to which the information this report is based on was accurate	14 November 2022
Senior Responsible Owner	Maria Wogan Chief of System Assurance and Corporate Services

The following individuals were consulted and involved in the development of this report:
This strategy has been developed following a ten-month engagement process with senior leaders including: - Maria Wogan, Chief System Assurance and Corporate Services, BLMK ICB - Felicity Cox, Chief Executive, BLMK ICB - Chief Executives from the local authorities - Directors of Adult Social Services

- Directors of Public Health
- Chief Executives from the local Healthwatch organisations
- Communication and Engagement leads from the Acute Trusts (hospitals)
- Voluntary and Community sector leads
- Leaders of the Councils
- Health and Wellbeing Board Chairs / Portfolio holders for Health and Wellbeing
- Overview and Scrutiny Committee (OSC) Chairs and Clerks
- Communication, Engagement and Equality & Diversity leads from partner organisations (provider organisations, local authorities, and emergency services)
- Primary Care Network (PCN) Clinical Directors
- Lay member for Patient and Public Engagement
- Patient and Young People representatives (from Patient and Public Engagement Committee)

Since the initial engagement exercise, the strategy has also received input from:

- The system wide community of practice for engagement and co-production which includes service users
- The Parent Carer Forum

This report has been presented to the following board/committee/group:

The ICB Executive team
The Working with People and Communities Committee
The system wide community of practice for engagement and co-production

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

The members are asked to **approve** the Working with People and Communities Strategy.

Executive Summary Report

1. Brief background / introduction:

Attached is the ICB's strategy for Working with People and Communities. It was developed in May this year, after four months of engagement with system partners (as highlighted in the section above) and following conversations with colleagues across the country who are known for innovative approaches community engagement, for example Wigan Council / The Wigan Deal and the London Borough of Islington / Fairness Charter.

The Strategy provides an overview of the legal duties of the Integrated Care Board and sets the framework for how we want to work with local communities to ensure they are given the opportunity to become involved in decision making about health and care in Bedfordshire, Luton and Milton Keynes.

A draft of the strategy was submitted to NHSE in May 2022 and NHSE considered it exemplary in several areas, in particular the Denny Review of Health Inequalities and the ICB governance.

Through the summer and autumn period, further engagement has taken place with committees, executives and engagement and co-production leads from across the system, Healthwatch, the VCSE, NHS Providers and local authorities.

Feedback has been incorporated into the strategy and the chapter on co-production has been co-designed by colleagues from across the system to ensure consistency in approach for this important strategy.

At the Board meeting, Miles Tringham the Participation Lead for Luton from East London Foundation Trust will present a case study on co-production to inform the Board's discussion on this element of the strategy. We are hoping to also hear from a resident who has participated in co-production so that the Board can hear the resident perspective on this work.

The Working with People and Communities Committee reviewed the strategy at its meeting in October and recommended the strategy to the Board for approval.

2. Summary of key points:

The strategy aligns the engagement and co-production strategies from partner organisations, includes principles of involvement from NHS England's guidance on working with people and communities and builds on the best practice approach established in our area through the pandemic.

The strategy's approach to working with local people and communities focuses on:

- Using insights and intelligence to supplement data to ensure decisions are taken with the lived experiences of residents in mind;
- Working with trusted people and advocates to ensure that authentic voices from all communities are heard;
- Working together with partners across the system to ensure the principle of subsidiary is delivered, to make connections with local people more meaningful and to establish one version of the truth;
- Engaging in continuous conversations with local people, so that they are involved in discussions about their health and care from a formative stage and have visibility on how their contribution is improving provision locally;
- Taking a neighbourhood first approach, so that conversations with local people are meaningful and focus on what matters most to them;
- Going to where people are to have discussions instead of asking them to adapt to systems which do not work for them;
- Embedding a consistent culture of co-production across the system, so that people are able to contribute as equal partners in the developing health and care services for themselves and their communities.

In the first year of this strategy, the focus will be to:

- Develop an insights bank to ensure lived experiences are shared across the system.
- Listen to the views of residents., especially those from seldom heard communities
- Develop a culture of partnership – working with leads from across the system to share skills, knowledge, frameworks, policies and resources
- Develop the community connectors who are trusted ambassadors within their communities, as a way of tackling health inequalities.
- Embed a training programme to support commissioners with co-production, co-design and involvement
- Embed a framework for co-production to ensure consistency of approach is adopted across the system.
- Develop a governance framework to support the sharing of information and intelligence and ensure that appropriate assurance is provided to the ICB.

- Establish evaluation and monitoring processes to benchmark our progress as an ICB.

3. Are there any options?

Not applicable

4. Key Risks and Issues

Not applicable

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

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

Funding for the development of the Insights Bank, the co-production training and the baselining for the evaluation and monitoring approach have been identified by the ICB and will be delivered in this transition year 2022/23. The ICB's Communications and Engagement Team comprise four staff who will be delivering the work programme in partnership with system partners.

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

Click to view Green Plan

The Working with People and Communities Strategy will support the Green Plan in engaging with local people in a two way continuous conversation to support the changes required to help people see the link between the way we behave, the resources we use, the climate and the impacts on health.

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

This strategy is designed to tackle health inequalities by opening new routes to engagement and involvement from all residents and communities in our area. It will ensure that trusted people can engage with seldom heard communities to enable their lived experiences to be considered in decision making about health and care services.

Central to this work is the Denny Review, which is a root and branch review into health inequalities in Bedfordshire, Luton and Milton Keynes. It is currently out in the field to engagement – and partners are listening to residents who have been seldom heard in decisions around health and care.

The engagement report, which will be published in January 2023, will identify recommendations to be taken forward which will tackle health inequalities and break down barriers to access.

8. Next steps:

On approval from the Board, the communications and engagement team will start to implement the actions as identified in the strategy.

9. Appendices

Appendix A – The Working with People and Communities Strategy.

10. Background reading

NHS England » Working in partnership with people and communities: Statutory guidance

NHS

Bedfordshire, Luton and Milton Keynes

Integrated Care Board

Working with People and Communities Strategy 2022 - 2025

Introduction and purpose

This document sets out the working with people and communities strategy for Bedfordshire, Luton and Milton Keynes Health and Care Partnership.

It has been produced following extensive engagement with system partners, building on the good practice adopted through the pandemic and setting out agreed principles to ensure local communities are involved in and empowered to make decisions about their health and wellbeing.

This strategy builds on the Working with People and Communities Guidance, published by NHS England in September 2022, but more importantly draws on feedback and lived experience from residents and strategies which system partners have co-produced with residents and service users.

The vision and mission of the Bedfordshire, Luton and Milton Keynes Integrated Care Partnership is simple. It aims to help everyone in our towns, villages and communities to live longer, healthier lives.

This strategy will help us to achieve this.

It will help us to address health inequalities, give a voice to local people and create a framework for us to work together in partnership.

Used well, the strategy will help us to spend tax-payers money well and improve the experience, outcomes, safety, quality and performance of health and care services.

By working with trusted organisations and going into neighbourhoods, rather than expecting people to come to us, we will better serve our communities.

We want to make sure we're living the spirit of this strategy and so following approval by the Board, a plain English summary will be produced for residents, together with accessible versions in community languages and easy read.

We are excited about the potential to work more collaboratively with partners and local people to make this strategy a reality.

Why working with people and communities matters

Through the engagement we have done, we've heard from the following organisations, individuals and groups on why working with people and communities matters.

A resident

I want to tell my story, but it's difficult to when the language is so complicated and the structures are difficult to understand.

Working with people and communities Committee

The voice of health and care professionals needs to be included and heard

The warn and inform communications group

The pandemic gave health and care organisations an opportunity to work together to deliver one goal – the safety of the public. What if we used that approach to work together to improve health and wellbeing and the quality of the services people access?

VCSE

There is a tremendous about of data in the health service, but there's limited intelligence and insight. It doesn't tell us what the lived experience has been and what we can do to change it.

Healthwatch

We regularly produce reports that provide lived experiences of health and care services, but it doesn't always result in action. Showing residents that their words have the power to change things will build trust and help to improve outcomes.

Local Councils

You can only build trust with local people if you 'walk the talk'. We need to keep talking to residents and show them how their feedback has influenced change – otherwise we'll never achieve the transformation we need to deliver.

BLMK Engagement Collaborative

The voice of service users needs to be heard in every single committee and forum, so we can make sure people who use the services has as much say, and we don't lose sight why we're doing this.

Our legal duties

The law and the triple aim

The powers that the Clinical Commissioning Groups had have been conferred on the ICB, which means the Board will need assurance that we're involving people in line with the legislation set out in the Health and Social Care Act, 2022.

NHS England, ICBs, NHS trusts and NHS foundation trusts are subject to the new 'triple aim' duty in the Health and Care Act 2022 (sections 13NA, 14Z43, 26A and 63A respectively) which means that:

1. It considers the health and wellbeing of people and the impact it has to inequalities
2. Quality of health services for all individuals, including the effects of inequalities in relation to the benefits that people can obtain from those services
3. The sustainable use of NHS resources.

New guidance

Guidance has recently been published which sets out the role that the Integrated Care Board (ICB) will have in working with Health and Wellbeing Boards (HWBB) in the new system.

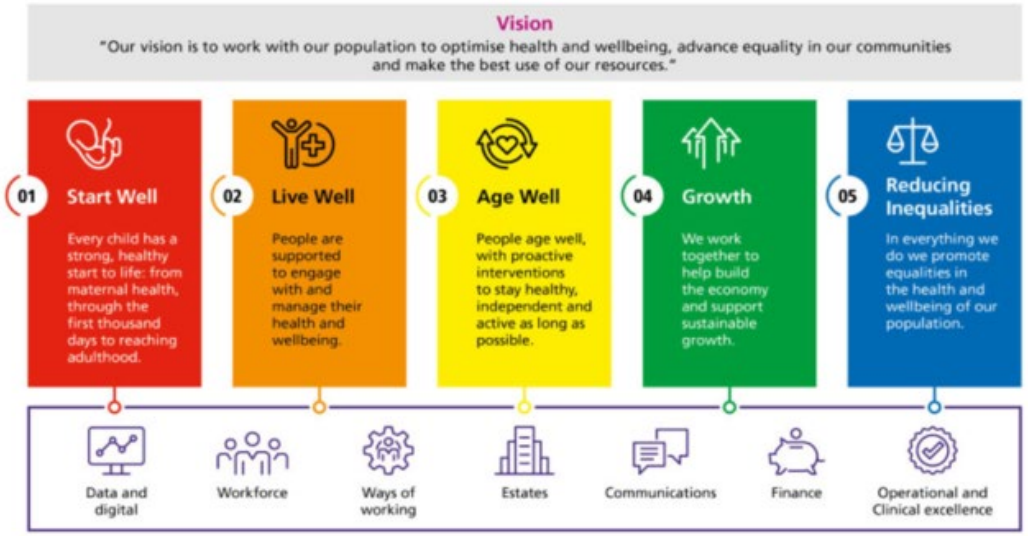
The guidance sets out that there will be continuity in the relationship between Health and Wellbeing Boards and ICBs, with ICBs building from the bottom up, following principles of subsidiarity, ensuring collaborative leadership and avoiding duplication.
https://www.gov.uk/government/publications/health-and-wellbeing-boards-draft-guidance-for-engagement

Guidance is also in development which will set out how ICBs will work with Health Overview and Scrutiny Committees. This is expected in 2023, following consultation with the Local Government Association, and the Centre for Public Scrutiny (CfPS).

Background and context

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

Supporting our priorities:
Communications is an enabler to support the deliver of the priorities for the system.



How we created this strategy:
Over four months, we worked with partners and residents. We held meetings and focus groups with NHS providers, councils, Healthwatch, the VCSE, NHS Foundation Trust Governors and Primary Care Networks to agree the principles we should adopt as a system.

What we heard?

- We need to listen more to lived experiences and provide insights and evidence to support data.
- Place is the most important factor. People who are seldom heard are more likely to engage with local organisations, leaders who are more relevant to them.
- Councils are the voice of local people and ward councillors have an important role in supporting engagement.
- Trusted people including clinicians will be more successful in accessing feedback from some communities.
- Co-production is the best way to shape health and care.
- Listen to patient experiences and share intelligence and insights.
- Trust Governors have an important tole to play as they are connected to communities they represent.
- We need to invest in working with communities.

Our strategy – shared principles

Our ambition - We want to build on the existing foundations and work to a common set of principles so we can make sure that lived experiences are at the heart of our work, and that people are given the opportunity to shape the services they receive.

Our principles - NHS England has consulted on a set of principles, which has been included in the Guidance for Working with people and communities.

During extensive engagement with the Engagement Collaborative, a group of co-production and engagement leads from across the system, it has been agreed that these principles should form the basis of the strategy in Bedfordshire, Luton and Milton Keynes.

Our strategy – eight pillars

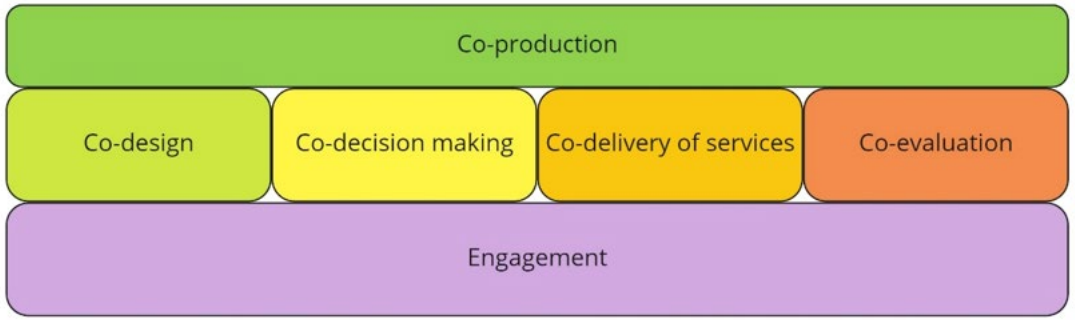
Act on insights – insights and intelligence heard from facilitated engagement, patient experience and discussions with communities should be reviewed, analysed, shared, and included in all activity across the system	**Think neighbourhood** – all participation should be meaningful, authentic, and culturally appropriate to the communities we are engaging. Keeping discussions local and relevant is the best place to start.
Work with trusted people – there are trusted people in the system who can open doors to communities and meaningful conversations. These could be faith leaders, the VCSE, GPs or people who work in the council in an advocacy role – for example the Gypsy, Roma, Traveller community.	**Go to where people are** – we know that people who experience health inequality don't engage with existing structures. To break down barriers, we must go to where people are, and consider intersectionality – for instance Muslim women can be engaged at the Mosque, but we can also hear their views via schools and workplaces.
Do it together – listening to local people, sharing information, and working together will help us to create a deeper understanding of the communities we serve and help to break down barriers, build on best practice and establish trust.	**Delivering the spectrum of involvement** – being consistent in our approach and engaging in several different ways will increase openness, transparency, communication, and discussion – and will help us to build strong relationships with local people.
Continuous conversations – and feeding back to people regularly to show how their views have made a difference will build trust with communities and increase participation.	**Co-produce –** co-production is an important function when working with people and communities and can empower communities shape services for themselves.

Strategic approach – We have developed eight strategic pillars for our working in partnership with people and communities' strategy, which brings together and aligns the strategies of partner organisations, builds on best practice established through the pandemic and reflects the statutory guidance produced by NHS England.

Introducing a system-wide co-production approach

What is co-production? *'A way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation.'*

Language is important when discussing co-production, as there is a difference between the two. Involvement means asking someone for their opinion, while co-production brings together people as equal partners and co-creators. It can be broken down into the following areas:



The benefits Co-production makes people feel heard and invested in, which helps build confidence, self-esteem and resident experiences.

What are the benefits?

- Find the effective solutions to healthcare challenges faster.
- Systems and services work better with fewer revisions
- Service users and residents who are actively involved in their care say they understand more and are invested u the service and care plan, so are healthier and happier.
- Expertise and resources increase when ideas are pooled together with people becoming experts in their own care.
- Services will be fit for purpose and tailored to the needs of the community.
- Increase community engagement with health care.

Co-production in BLMK

The principles of co-production

- Recognising and valuing the lived experiences of our community
- Building on the individual and community skills
- Making sure we work together in an equitable way, and the work we do together represents the views of the whole community
- Developing relationships across the whole community that benefit local health and wellbeing
- Making sure we work together at every stage of development from planning and design to governance and evaluation.
- Making sure that everyone working together to develop health and social care has the resource and training to do so

Embedding co-production across the system

A support package will be provided, which includes bespoke training, community of practice events and support packs to help colleagues with a step by step approach.

Values and behaviours

Implementing co-production in BLMK

Leadership: Visibly support and sponsor collaboration through culture behaviours and relationships, including senior leadership role modelling.

Inclusivity: Use open and fair approaches to recruit a range of people who use health and care services, carers, and communities, taking positive steps to include under-represented groups.

Educate and train: developing staff and citizens so that everyone understands what collaborative working is and how to make it happen.

Reward and recognition: Developing systems that reward and recognise people's contribution.

Review and Report: Regularly assessing progress, moving from 'you said, we did' to 'we said, we did'.

Evolve and perfect: Building the collaborative approach into all our work programmes until it becomes 'how we work'.

Prioritise and begin: identifying work where collaboration can have the greatest impact, involving people in the earliest stages of design.

Actions not words…a case study

The Denny Review

Reverend Lloyd Denny, a respected community leader from Luton was asked to lead a review of health inequality in Bedfordshire, Luton and Milton Keynes in the aftermath of the pandemic. The review looked to build foundations for community engagement learned and adopted during the pandemic and to trial new ways of working with partners, in line with the guidance issued by NHSE and the principles outlined in this working with people and communities strategy.

Partners from across the system were invited to form a steering group, which would be responsible for delivering the review. Led by the Chief Executive of East London Foundation Trust, and comprising of members from local councils, public health, Healthwatch and VCSE and other NHS providers, the steering group commissioned the University of Sheffield to undertake a literature review to better understand what information had been compiled to date about health inequalities in the area and provide recommendations for further engagement and study.

The recommendations outlined that the communities which experienced the greatest health inequalities in our area were: Gypsy, Roma, Traveller, LGBTIQ, people living in deprived areas from ethnic minority backgrounds, people living in deprived areas with both physical and learning disabilities, migrants and homeless people. The evidence gathered also outlined areas for focus including communication barriers, NHS culture and culture and religion.

Using population health data from the emerging Integrated Care Board, wards and postcodes were identified as target areas for engagement to be undertaken. Healthwatch and the VCSE are currently working together to undertake engagement in these areas, working together with trusted people and going into the places where people are, so we can better understand the issues around communication, NHS culture and religion and culture.

Recommendations will be taken from this engagement work with the view to co-producing solutions with communities and informing the strategy for the Integrated Care Partnership. This will help us to build relationships with local people, breakdown barriers and tackle health inequalities. The Denny Review is expected to report in January 2023.

Putting strategy into action Year one plan 2022 - 2033

Our engagement with partners and residents identified key areas of focus in the first year of this strategy. Our priorities include:

- **Listening to resident voices** and giving people the opportunity to share their views is a top priority. There are existing resident and service user groups established across the system and we are exploring ways to build on this, whether through citizen panels or communities of interest to ensure that all voices are heard (November 2022 – March 2023).
- **Building a culture of partnership** – working with co-production and engagement leads from around the system to provide leadership and support in embedding new approaches and co-production – including an extensive programme of training and materials to support new approaches in embedding into the system. (August 2022 – March 2023).
- **Working together to establish core community connectors** which will help us to listen to authentic lived experiences and work together to tackle health inequalities and remove barriers to good health. (October 2022 - March 2023)
- **Rolling out a system agreed development programme** to support commissioners and resident facing officers in understanding the legal duties placed upon them and provide them with the skills and knowledge to deliver co-production and involvement as set out in the strategy and co-produced framework for co-production (December 2022 – March 2023).
- **Establishing governance processes** to centre decision making and governance around the voices of people and communities and ensure that there is appropriate and professional system wide support and challenge in place, to provide assurance to the Board that we are delivering on our legal duties. (July 2022 – December 2022).
- **The development of an insights bank** to capture insights from engagement taking place across the system, to ensure that we learn from what works and build on the assets of all health and care partners, networks, relationships and activities in local places. (August 2022 – March 2023).
- **Work in partnership to co-produce a framework and principles for co-production** that can be shared across the system as best practice and the standard for participation. (October 2022 – March 2023).
- **Evaluation and monitoring framework** established to benchmark reputation and performance. (January – March 2023)

Providing Board assurance

The Board has a statutory duty to ensure that we are delivering on our duties to involve. To provide assurance that all guidance is adhered to and good practice is consistent across the system, we have established a Working with People and Communications Committee, which is a formal committee of the Board and meets quarterly. The committee comprises:

- Non-Executive Member (Chair) – Manjeet Gill
- Associate Non-Executive Member (Deputy Chair) – Lorraine Mattis
- Chief of System Assurance and Corporate Services (Lead Exec) – Maria Wogan
- NHS Trust/Foundation Trust Partner Member – Ross Graves
- Primary Medical Services Partner Member – Mahesh Shah
- Local Authority Partner Member – Laura Church
- Healthwatch representatives from:
  - Bedford Borough, Helen Terry
  - Central Bedfordshire, Diana Blackmun
  - Luton, Lucy Nicholson
  - Milton Keynes, Maxine Taffetani
- Voluntary, Community and Social Enterprise Representative – to be appointed
- Health and Care Senate Representative – to be appointed
- Chief Transformation Officer – Anne Brierley

Supporting the Committee – BLMK Engagement Collaborative

A community of practice of engagement and co-production leads from across the system has been established to support the work of the committee.

This engagement collaborative will contribute to development of a work plan for the committee, so that leads from across the system can provide updates on how they are working and co-producing with local residents in their Trusts and authorities.

Lived experience leads

The engagement collaborative have advocated for people with lived experience to be members of the group, to ensure that local people also have a role in providing assurance to the board that statutory guidance is being followed.

How will we resource the plan?

Throughout the pandemic a communications cell was established with the NHS as the lead agency which allowed partners to use expertise from different organisations to maximise capacity and resources.

We are using this same approach to maximise resources and reduce duplication, as the Integrated Care System establishes.

Two collaboratives have been established to bring communications and engagement people together from across the system. These are:

- The Communications Collaborative – a group of communications professionals from all Trusts, local authorities and NHS Providers.
- The Engagement Collaborative – a group of engagement and co-production leads from Healthwatch, NHS Providers, local councils and the VCSE.

This approach will help to reduce duplication and will enable matrix working as some communications and engagement functions are devolved from the centre to place.

The ICB's communications and engagement team include four WTE delivering the following functions:

- statutory engagement and involvement
- communications and engagement support at scale, collaborative, and place
- internal communications support
- strategic communications, digital and design (CSU provided)

With the introduction of the insight bank in this transition year, there is a requirement for additional analytical expertise to be provided, so that we can provide trend analysis and horizon scanning to the Board.

During 2022/23 we will work flexibly with partners to evolve our operating model based on the principle of subsidiarity.

Evaluation and monitoring

Monitoring and evaluation will play an integral role in monitoring success and assessing whether the outputs contained within this strategy have changed behaviours and increased participation.

We are currently working to co-design with partners an evaluation framework for working with people and communities which will:

- Provide assurance to the Board of the Integrated Care Board
- Demonstrate the impact of working with people and communities
- Enable local people, communities, the Board of the Integrated Care Board and NHSEI to hold us accountable

The framework will be co-designed with partners, local people and communities to provide a range of qualitative and quantitative measures to demonstrate how people see us.

How this will work?

The Denny Review outlined in this document will draw on discovery interview methodology, to provide quantitative insights from residents about the experience they have and what changes they would like to see made to reduce barriers to health.

This approach will also be used as part of the development of citizens panels/communities of interest (as outlined earlier in this strategy). A small number of interviews – no more than 50 at any one time will be held to listen to views of specific communities about our services.

A quantitative approach will also be used to generate a broader picture, including:

- A public sentient tracker questionnaire conducted in two waves with samples who were demographically similar and were based across our population
- A stakeholder sentient tracker which includes 14 interviews with stakeholders to monitor perceptions.

Together these insights would completed annually to show progression and highlight the areas that are most important to residents in our area.

Next steps?

Our working with people and communities strategy will remain a living document and will continue to be periodically reviewed as we adapt to challenges and opportunities.

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

This strategy has been developed in collaboration with partners from across the system, from NHS Providers to local councils, the VCSE, Healthwatch, clinicians, patient experience leads and residents.

We would like to thank them for their input, honesty and willingness to get involved to make a positive difference to the people and communities we serve.

In keeping with the spirit of this document, a plain English version will be developed and published on our website / shared with councillors. We will ensure that there are accessible versions of the document and videos produced which will enable people with protected characteristics to understand and contribute to the new way of working.

Glossary of terms

Integrate	A principle of the programme, which refers to creating more co-ordinated care for the patient, making sure all parts of the NHS and social services work more closely and effectively together.
The Integrated Care System (ICS)	In an integrated care system, the NHS organisations in partnership with local councils and others take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.
The Integrated Care Board (ICB)	A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in Bedfordshire, Luton and Milton Keynes.
The Integrated Care Partnership Joint Committee (ICPJC)	A statutory committee jointly convened by the local authorities in our area and the Integrated Care Board. It comprises a broad range of partners and is responsible for developing an integrated care strategy setting out how the wide-raging health needs of the local population will be met, accounting for any relevant joint strategic needs assessments produced by Health and Wellbeing Boards, involving local Healthwatch, Voluntary, Community and Social Enterprise Sector and people and communities living in the area.
NHSE	NHS England – the regulator organisation for the NHS including the Integrated Care Board, hospitals, mental health trusts, GP surgeries etc.
Primary Care Networks (PCNs)	Primary Care Networks are groups of GP practices usually serving approximately 30-50,000 patients working together to focus on improving patient outcomes for their local population.
Neighbourhoods	Local areas where people live including patient's registered by GP practices and also those who may choose not to
Places	A local authority area i.e., Bedford Borough, Central Bedfordshire, Luton, and Milton Keynes.

People and residents	Everyone of all ages, their representatives, relatives, and unpaid carers.
Health and Care Act, 2022	The new law that has been passed by parliament. Section 14Z44 of the Act is the section of law that relates to involving residents in shaping health and care. This is a legal duty that the Integrated Care Board is responsible for delivering.
Communities	Groups of people that are connected by where they live or the interests they share.
VCSE	Voluntary, Community and Social Enterprise Sector - organisations run mostly by volunteers who work at a local level to help local people.
Multi-agency	A group of organisations working together on one thing or service – such as a crisis like the Covid-19 pandemic.
Engagement	Seeking local views, listening and feeding back what has been heard and how this is shaping health and care.
Involvement	An action to become involved with something – shaping health services or speaking to local people.
Consultation	Usually, a formal 12-week process to listen to local people and ask their views on proposals for change to services. All formal consultations are shared with a legal committee run by the local council, called a Health Overview and Scrutiny Committee. Councillors who sit on the committee review the proposals and make sure that residents are given the opportunity to share their views. They also review the findings to make sure that resident views have been taken into consideration.

Communications	Sharing information with people about the work that we are doing. This takes many different forms from newsletters and news stories to face to face discussions, briefings and website information.
Committee	A group of people who are tasked with looking at the work that is being done in an area of the business – for example the Working with People and Communities Committee that looks at how we are communicating and working with local people.
Statutory duties	The laws that organisations like local councils and the NHS are required to deliver. For example, the requirement to involve local people in shaping health and care locally.
Participation	Getting involved in discussions and meetings about services and how they are run or sharing your views about a service you have accessed.
Subsidiarity	Decisions made at the most local level, as close as possible to the communities they effect.
Cultural change	Changing the way that organisations have worked so that it meets the needs of local people.
Co-production	Co-production is where local people and professionals come together as equal partners to find solutions or design how services are run.
Co-design	When people work together to design something – whether a leaflet, a training course or a service.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care board
9. – Voluntary, Community & Social Enterprise Sector and ICB Memorandum of Understanding

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	Sonal Mehta, VCSE Partnership Lead
Date to which the information this report is based on was accurate	14/11/2022
Senior Responsible Owner	Maria Wogan, Chief of System Assurance and Corporate Services

The following individuals were consulted and involved in the development of this report:
• Three workshops with BLMK VCSE colleagues • One workshop with BLMK VCSE Strategy Group • Attending meetings with LA and ICB colleagues • Informal discussions with Healthwatch colleagues • A joint workshop with system and VCSE colleagues
This report has been presented to the following board/committee/group:
• Initial presentations to the ICB Executive meeting and Working with People & Communities Committee

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

The members are asked to:

a) **approve** the ICB and VCSE Memorandum of Understanding and authorise the Chair of the ICB to sign in the Board's behalf

b) **request** all the Place boards to discuss how the Memorandum of Understanding is being implemented at Place at their next Place Board meetings

Executive Summary

1. Brief background / introduction:

There is a long and trusted relationship with the Voluntary, Community and Social Enterprise (VCSE) sector across BLMK, at place, alliance and system level. The creation of the Integrated Care Board provides an opportunity for the VCSE to be an equal strategic partner with the strategic organisations to work together in developing and implementing plans for our residents. The links with VCSE have been strengthened during the pandemic which saw community organisations mobilise to support residents and, where there were gaps in local provision, new community groups were created e.g. Leighton Linslade Helpers, that provided support included getting shopping, collecting and delivering medication and initiating a foodbank and community kitchen.

Establishing effective and integrated working with the VCSE is critical to the ICS achieving its four core objectives 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 and economic development.

Currently the VCSE are supporting Mental Health projects across BLMK from Children and Young People, bereavement, dementia, advocacy, suicide prevention and digital. In BLMK there are sixteen VCSE organisations actively involved in initiatives to prevent suicide which is the biggest cause of death of men and women aged 20-34. An example of the support is YIS Young Peoples Mental Health which provides therapeutic counselling for young people at risk of suicide.

To enable the VCSE to be central to the work of the ICS we have invested in capacity to develop the necessary supporting infrastructure and as part of this work we have drafted a memorandum of understanding between the VCSE and the ICB to formalise our commitment to working together, to describe our strategic intent for the relationship and to set out the way in which we will work together to build a sustainable and effective partnership. The importance of the VCSE in system working is reflected in the Health and Care Act 2022 and Report template - NHSI website (england.nhs.uk) which requires ICB's to have a formal agreement for engaging and embedding the VCSE sector in system-level governance and decision-making arrangements at all levels of the system, ideally by working through a VCSE alliance to reflect the diversity of the sector.

The ICB funded VCSE Lead has been instrumental in developing the BLMK VCSE strategy group which has membership from the VCSE infrastructure organisations in Milton Keynes, Bedfordshire and Luton and other BLMK VCSE organisations. The BLMK VCSE Strategy Group has been overseeing the development of this strategic, equal partnership. There are three main areas that this covers –

1. Development of partnership working within the VCSE
2. Embedding VCSE representation within system governance and decision making

3. Improving VCSE participation in system transformation workstream development and delivery

   It is also recognised that the VCSE sector provides valuable insight through working with community groups. This is reflected in and key to the delivery of the Working with People and Communities Strategy that defines the involvement of residents, local community groups and people with lived experience in the design of services to meet their needs.

   It is recognised that this is a transitional year for the ICB and the relationship with the VCSE continues to be developed strategically and locally. The MoU sets the direction of travel between the VCSE and the ICB. The MoU has been written and co-designed by colleagues from across the statutory and VCSE sectors. In order to develop the MoU, engagement happened organically in a range of forums over the last six months. The MoU has been developed based on learning from other systems and with support from NHSE. The MOU details the commitments required by the ICB and the VCSE sector as detailed below:

ICS commitments

- When a need for representation is identified (by either party), we will recognise, respect, and work with the pathways that will be established for engagement with the VCSE.
- We recognise the difference between VCSE representation and VCSE participation and will recruit to boards and working groups with this difference in mind.
- We will welcome input from the VCSE sector to ensure senior ICS system leaders are informed about what is important to the sector and communities. We are committed to an ongoing dialogue with the VCSE sector and respect them as an equal strategic partner.
- We value the infrastructure for the VCSE sector and support this where we can, including funding it where possible, relevant and appropriate, with agreements that are meaningful to both sectors
- We commit to appropriate and proportionate commissioning processes for the VCSE sector. This includes frameworks and grant funding and consideration for length of contracts and grants. We understand the need for timely payment of invoices. We also recognise the importance of full cost recovery and are committed to commission on this basis.
- We recognise that the VCSE is an equal partner that sometimes has a different perspective. We respect the sector's right to challenge and campaign without this impacting on the funding relationship with the ICS.

VCSE Commitments

- We will prioritise areas of our strategic engagement with the ICS based on VCSE capacity and a mutual agreement concerning where we add most value.
- We will appoint representatives who have a mandate to speak on behalf of the VCSE sector. They will be appointed on the basis of a commitment to maintaining their impartiality, reflecting a diversity of perspectives, clearly articulating our collective messages and openly sharing information and opportunities with the VCSE sector.
- There will be times where people from the VCSE sector attend ICS boards / working groups outside of this structure and represent their own organisations and speak from their own perspectives.
- The VCSE sector will work collectively to take a strategic lead and define its priorities based on local intelligence.
- We will collaborate within the VCSE sector to work strategically with the ICS; this includes building relationships and cohesion within the sector, exploring opportunities for joint working and sharing information and resources.
- We will participate in service design, strategic planning and prioritisation including undertaking commissioned work to support the ICS to involve local communities and communities of interest in the planning and design of services.
- We will create volunteering opportunities, strengthening community cohesion and resilience by enabling staff and residents to contribute their skills and time

A cross sector workshop was held on 9 November 2022 to understand how the MoU can deliver on the ambitions described within it. A Year One plan will be created which will describe the ways in which we will further develop partnership working and understand how we measure success. This plan will be reviewed within the year to ensure the investment into the VCSE is commensurate with our ambitions.

The draft memorandum of understanding is presented for approval by the Board. It is expected that this MoU will evolve over time and in the light of the development of the implementation plan and therefore an update will return to the Board in January and March. To help inform the development of the implementation plan based on the principle of subsidiarity it is proposed that the MoU should be discussed at the Place Boards at their next meeting.

2. Summary of key points:

2.1 There is an established trusted relationship between the VCSE and the statutory partners in the ICB and the MOU seeks to formalise the commitment from the ICB and VCSE to work together as strategic partners. The MOU is a statement of intent on how we will work together on strategic issues for example involvement of the VCSE in the operational planning process.

2.2 The MOU has been developed from best practice in other ICBs, the BLMK VCSE strategy Group and the Working with People and Communities Committee. The MOU will continue to be developed by the ICB and VCSE over time, in recognition of the recent establishment of the ICB and building on collaborative working.

2.3 A VCSE workshop was held on 9 November which had working groups considering the challenges and opportunities of the ICB and VCSE working more collaboratively. It also discussed how the MOU would enable us to meet our goals and how we would measure success. The outputs from the workshop are being collated and from this a year one action plan will be developed and reported to the ICB Board in January or March 2023. This will include a future operating model, specifying resources required for delivery and which may include a re-purposing of existing ICB resources as part of the development of the ICB's operating model.

3. Are there any options?

There are options for implementing the MoU will be developed as part of the implementation plan which will be reported to the ICB Board in January or March 2023.

4. Key Risks and Issues

Much of the sector is experiencing **financial and workforce pressures.** This is amplified by:

1. The impact of COVID,
2. The cost of living crisis and inflation
3. Short term funding

All of these factors are having a significant impact on sustainability, recruitment and retention. It also affects capacity within the sector to be able to effectively engage with the ICB.
The development of this MoU and underpinning workplan seeks to mitigate some of these impacts.

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

5. Are there any financial implications or other resourcing implications, including workforce?
None from this report. A further report will be made to the Board on the year one plan which will identify actions, outcomes, milestones and resources required for delivery.
6. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan
The VCSE will continue to be engaged as a key partner is this area.
7. How will / does this work help to address inequalities?
The VCSE is an essential partner in our approach to reducing inequalities.
8. Next steps:
Following approval by the ICB the MoU will be returned to the VCSE strategy Group for signing. A Year One plan to underpin the MoU will be developed further between the VCSE and ICB colleagues based on discussions from the workshop. Agree milestones and resources to support the Year One plan
9. Appendices
Appendix A – VCSE MoU
10. Background reading
NHSE - ICS implementation guidance on partnerships with the voluntary, community and social enterprise sector Report template - NHSI website (england.nhs.uk)

APPENDIX A

Bedfordshire Luton and Milton Keynes Health and Care Partnership and Voluntary, Community and Social Enterprise Memorandum of Understanding

Introduction

The Bedfordshire, Luton and Milton Keynes Health and Care Partnership is a group of local authorities, NHS organisations and the voluntary, community & social enterprise (VCSE) sector, working together with our population to support and improve health and wellbeing in our area. Our aim is simple - we want everyone in our city, towns, villages and communities to live a longer, healthier life.

When we talk about the VCSE in BLMK, we mean charities, voluntary organisations, community groups, faith groups, and those social enterprises where profits are reinvested in their social purpose. This breadth and depth is its strength and the sector brings specialist expertise and fresh perspectives to public service delivery. It has a long track record in promoting engagement and finding creative ways to improve outcomes for groups with the poorest health, making it an essential partner in addressing health inequalities.

The VCSE sector is already working across areas such as skills, employment and enterprise; housing and transport; environment and carbon reduction; poverty reduction; inclusive economic growth and inclusive governance. In addition, many of them are already active in community development, social movements, health creation, and social innovation. The sector boasts an impressive overview of how health and social care and other agendas are interconnected.

Purpose

This Memorandum of Understanding (MOU) is a written understanding between the Bedfordshire, Luton and Milton Keynes Integrated Care Board and the VCSE sector to detail how the two will operate and to ensure integration to realise the potential of working together.

The purpose of this MoU is to establish an adaptable and flexible framework that brings supports the development of mutual understanding between partners and a culture of learning. It will demonstrate shared vision and values, putting people in our communities at the heart of everything we do. The MoU will build on existing partnership working and dynamic relationships, committing resources, energy and passion to integrated working to achieve our collective aims and objectives as equal partners. We recognise that this is the first step in developing an equal partnership.

Background

Bedfordshire, Luton and Milton Keynes Health and Care Partnership is committed to formalising a strategic partnership with the Voluntary, Community and Social Enterprise sector, building on existing structures and engagement at neighbourhood, place and system. A Voluntary, Community and Social Enterprise sector partnership forum is being developed through the established Bedfordshire, Luton and Milton Keynes Voluntary, Community and Social Enterprise sector strategy group.

This group acts as a conduit to engage the sector more widely and ensures Voluntary, Community and Social Enterprise sector partners are embedded at all levels of governance

and decision making across the system. The Bedfordshire, Luton and Milton Keynes Voluntary, Community and Social Enterprise sector partnership lead is a member of the of the Health and Care Partnership Joint Committee.

Shared Principles and Values

The following are the shared principles and values of the Health and Care Partnership and the VCSE in BLMK:

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

VCSE vision

A vibrant, sustainable and resilient Voluntary, Community and Social Enterprise Sector which is participating across all levels and places within the Bedfordshire, Luton & Milton Keynes Integrated Care System. The VCSE is recognised as an equal partner for the expertise it brings in shaping strategies and in planning and delivering services for the benefit of the population.

Governance and Connectivity

The BLMK VCSE strategy group will influence and facilitate greater collaboration between the BLMK Health and Care Partnership and the VCSE Sector, enhancing the role of the VCSE sector in the delivery of the transformation of health and wellbeing and cementing their role as a key strategic partner. The VCSE sector is a key part of the ICS and therefore it forms part of the overall governance of how the BLMK Health and Care Partnership will operate.

The BLMK VCSE Strategy Group enables connectivity of the wider sector and the VCSE is increasing representation on certain boards. The VCSE Strategy Group has core membership from identified infrastructure organisations across BLMK and places for Health and Wellbeing Board VCSE representatives from all four local authorities. Membership of the group will evolve as partnership arrangements mature. A range of VCSE organisations will have been participating in working groups prior to the development of a strategic partnership.

The Strategy Group recognises that the VCSE sector needs to maintain a flexible architecture to operate with maximum impact across BLMK. Most of the work will happen at a ‘place’ level, however where relevant, decisions or work may need to happen at a system level or cross boundaries. The group will support the development of a BLMK VCSE Partnership Forum to ensure there are opportunities to engage at a system level, where it makes sense to do so.

In Milton Keynes, the infrastructure organisation Community Action:MK, along with other VCSE organisations is facilitating a place-based alliance of VCSE organisations that can

work with the Milton Keynes Health and Care Partnership to deliver on local priorities, as agreed in the MK Deal. MK membership of the BLMK Strategy group is drawn from the MK VCSE alliance. Members of the group from across the county of Bedfordshire are those that have capacity and purpose to engage at a system level.

There is one dedicated infrastructure organisation, CVS Bedfordshire, covering the county of Bedfordshire, alongside other VCSE organisations and local authority teams that provide an infrastructure function. Each of the local authorities of Bedford Borough, Central Bedfordshire and Luton will work with the VCSE networks across Bedfordshire to engage with local decision-making structures, and where appropriate, the Bedfordshire Care Alliance.

The VCSE sector will also be a key component to workstreams and themes at place, care alliance and system levels. We will ensure VCSE representation in these areas is strong and utilises the strengths and knowledge of wider VCSE organisations, ensuring the appropriate level of contribution in the right areas.

The VCSE will work alongside the other partnerships within the BLMK system, with responsibility as agreed with the Integrated Care Board (ICB) and local authorities. In addition, the VCSE will work with the other partnerships on their responsibilities and integrate the work of the sector to support and deliver against other outcomes. A non-executive member of the ICB will have VCSE partnerships as part of their portfolio to ensure the appropriate level of profile and visibility at a strategic level.

Joint commitments

- For the next 12 months we commit to the undertakings described in this document. We will hold each other to account, live our values and regularly review our working relationship.
- We will collaborate to maximise on the opportunities and share the risks to achieve the best possible outcomes for individuals, communities and our organisations.
- We see each other as critical friends. We will invest time in learning about each other's sector, developing mutual understanding and assimilating our learning into our behaviours and practice.
- We will hold spaces to have difficult conversations when required, committed to being open to ideas, debate, challenge and discussion, through formal and informal channels. This will include developing a dispute resolution process.
- To ensure we work in a trusting relationship we commit to being as transparent as we can be, whilst recognising that there are times this is constrained. Transparency by the ICS about where and how decisions are made is key for the VCSE sector to have equality, equity and parity of power in influencing decision making. Transparency by VCSE sector organisations about their characteristics, successes and challenges is key to citizens gaining the greatest possible benefit from services.
- We will develop engagement structures that enable VCSE organisations to have a voice on issues that matter to them and the communities they work with. This will be done in a way that is proportionate, impactful, and fair.

ICS commitments

- When a need for representation is identified (by either party), we will recognise, respect, and work with the pathways that will be established for engagement with the VCSE.

- We recognise the difference between VCSE representation and VCSE participation and will recruit to boards and working groups with this difference in mind.
- We will welcome input from the VCSE sector to ensure senior ICS system leaders are informed about what is important to the sector and communities. We are committed to an ongoing dialogue with the VCSE sector and respect them as an equal strategic partner.
- We value the infrastructure for the VCSE sector and support this where we can, including funding it where possible, relevant and appropriate, with agreements that are meaningful to both sectors
- We commit to appropriate and proportionate commissioning processes for the VCSE sector. This includes frameworks and grant funding and consideration for length of contracts and grants. We understand the need for timely payment of invoices. We also recognise the importance of full cost recovery and are committed to commission on this basis.
- We recognise that the VCSE is an equal partner that sometimes has a different perspective. We respect the sector's right to challenge and campaign without this impacting on the funding relationship with the ICS.

VCSE Commitments

- We will prioritise areas of our strategic engagement with the ICS based on VCSE capacity and a mutual agreement concerning where we add most value.
- We will appoint representatives who have a mandate to speak on behalf of the VCSE sector. They will be appointed on the basis of a commitment to maintaining their impartiality, reflecting a diversity of perspectives, clearly articulating our collective messages and openly sharing information and opportunities with the VCSE sector.
- There will be times where people from the VCSE sector attend ICS boards / working groups outside of this structure and represent their own organisations and speak from their own perspectives.
- The VCSE sector will work collectively to take a strategic lead and define its priorities based on local intelligence.
- We will collaborate within the VCSE sector to work strategically with the ICS; this includes building relationships and cohesion within the sector, exploring opportunities for joint working and sharing information and resources.
- We will participate in service design, strategic planning and prioritisation including undertaking commissioned work to support the ICS to involve local communities and communities of interest in the planning and design of services.
- We will create volunteering opportunities, strengthening community cohesion and resilience by enabling staff and residents to contribute their skills and time

Resourcing

BLMK Health and Care Partnership/ICB will provide appropriate resources to support collaborative activity and capacity from members to support the operations of the VCSE Strategy Group and Partnership Forum to deliver on agreed programmes and projects at system, Place and alliance. In addition, the BLMK ICB will directly fund agreed core posts.

Funding and staffing resources will be reviewed on a regular basis in line with emerging needs and priorities. The VCSE Strategy Group will identify and secure additional external investment to deliver on the plans and priorities of the partnership and wider VCSE sector.

BLMK also recognise of value of the VCSE at Place, as key independent partner and ensuring sustainability of the sector's contribution and allocate appropriate resources that enable strategic partnership working.

November 2022

Signed on behalf of the VCSE:

Signed on behalf of the ICB:

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Report of the Board of the Integrated Care Board
10. BLMK Fuller Programme – Progress Update

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

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

Report Authors	Nicky Poulain, Chief Primary Care Officer, Amanda Flower, Associate Director Primary Care Commissioning & Transformation.
Date to which the information this report is based on was accurate	14.11.22.
Senior Responsible Owner	Nicky Poulain, Chief Primary Care Officer.

The following individuals were consulted and involved in the development of this report:
Engagement with the four place boards is underway.
This report has been presented to the following board/committee/group:
As above.

Purpose of this report - what are members being asked to do?
The members are asked to **note** the report and progress.

1. Brief background / introduction:
The BLMK Fuller Programme is a system programme with the aim of anchoring transformation around our neighbourhoods using the 'Place Boards' to implement the recommendations of the Fuller stocktake published in May 2022.
2. Summary of key points:
The programme is supported by the ICB Primary Care team and the ICB PMO Team and 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. The ICB Fuller Programme Working Group will track progress, resolve escalated issues, and ensure system connectivity including workforce, digital technology, any identified organisational barriers. The BLMK Fuller Stakeholder Collaborative Group will ensure the programme is 'Place' and neighbourhood sensitive, adopting the principle of subsidiarity and meeting the needs of local people to enabling and embed place-based transformation.
3. Are there any options?
These will be identified during the development of the 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 ☒

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?

Focus is to provide continuity of care for those in Core20plus5.
8. Next steps:
Continue to develop the BLMK Fuller Programme Plan with system partners.
9. Appendices
Appendix A – Map to show Collaboration and Connectivity
10. Background reading
NHS England » Next steps for integrating primary care: Fuller stocktake report

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Integrated Care Board

BLMK Fuller Programme – Progress Update

14 November 2022

1. Background

Following the publication in May 2022 of 'Next steps for integrating primary care: Fuller stocktake report' and the subsequent 'Implementing the Fuller Review briefing paper' discussed at the BLMK Integrated Care Board in July, this report provides an update of our BLMK Fuller programme.

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

Socialising the 'Fuller' report's recommendations has taken place across our system with stakeholders exploring how the recommendations should be applied at neighbourhood, place, and scale within BLMK. It is widely recognised that there is significant progress in our system on which we can build, for example 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.

It has been recognised locally and nationally that the Fuller report, whilst not necessarily providing 'new' concepts, it provides an extremely useful framework from which resilient, integrated and appropriately scaled primary care can be developed in the ICS. Strong and stable general practice is the foundation of primary care at scale, system working and the wider NHS.

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. Place boards are affiliated and support our vibrant voluntary and community sector and in collaboration with NHS and Local Authority health and care services,

networked discussions are taking place. 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. An example is targeted interprofessional work for people included within Core20plus5 supported by the teams across the ICB. Local innovative 'virtual' teams are beginning to evolve consisting of CVSE, health and care providers to realign services and workforce to communities driving the shift to a proactive and holistic approach to health and care. An example of this includes working together to ensure there are 'warm spaces' for residents most affected by fuel poverty. There is evidence of a cultural change of 'how teams work can work differently together to maximise their joint impact on health outcomes' ultimately to support residents to live as healthy a life as possible.

Building capacity and capability using the associated funding with the additionally funded PCN (ARRS) roles is significantly supported by the ICB's Primary Care and the People teams to help create the environment for PCNs to flourish as key enablers of the neighbourhood teams.

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

1.	Map current neighbourhood team 'ways of working' / structures (embryonic or developed) by PCN/Place	Q2 & Q3 - 2022/23
2.	Develop vignettes of current arrangements to demonstrate the potential/opportunity – what does good look like	Q2 & Q3 – 2022/23
3.	Undertake a full stakeholder/provider analysis at place/PCN to identify who will contribute to neighbourhood team	Q3 & Q4 - 2022/23
4.	Map community health service provision around PCN populations to identify unwarranted variation and risks to neighbourhood delivery	Q3 & Q4 - 2022/23
5.	Triangulate the PCN maturity matrix with Fuller Neighbourhood vision to establish readiness	Q3 & Q4 – 2022/23
6.	Agree with partners the blueprint for neighbourhood teams in BLMK that can be used to support place/PCN development/implementation.	By 31st March 2023

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

The most well-developed workstream of the BLMK Fuller programme is 'Primary Care Access' and specifically the 'urgent same day access' offer to patients. This access workstream has robust and dedicated clinical leadership.

It is evident that access to same day urgent care has changed through the pandemic and is continuing to change. 93 practices in BLMK manage flow according to the capability of their infrastructure and consequently impacts the utilisation of 111 and the integrated urgent care offer (clinical assessment service and out of hours service). Currently, activity in Urgent Treatment Centres, Urgent GP Clinics, and 111 and A&E is variable and unpredictable. There are considerably more calls to 111 during 08.30 - 18.30 when GP practices are open, than pre pandemic and there is continued increase in demand, outside these hours and over the weekends and Bank Holidays. There is aligned and focused work within the ICB, to support staff recruitment, training, and retaining

our workforce in the area of 'urgent care' as it is a pressuring and demanding place to work for both clinical and non-clinical staff.

This month's priority has been the launch of our 'GP Access communication campaign' across the BLMK system using a data driven approach to help our communities understand the true picture. Clinical leadership has been central to this campaign.

Primary care clinical leaders, primary care networks and primary care providers support finding a scaled and integrated solution to same day urgent primary care.

The transformation required to achieve an improved offer for 'access to same day urgent care' is being underpinned by a sophisticated demand management exercise which is multifaceted. There are currently numerous services across BLMK that influence and impact the integrated urgent care access offer and we need to include all services in the review to ensure we build the right capacity for our population. The system offer aims to facilitate self-care, plus using and utilising the right workforce not just general practice. This important work will help to differentiate routine primary care, where currently, our population needing on-going care for complex or long-term conditions compete for appointments with patients wanting infrequent same day care such as respiratory infections. Integrated urgent same day care at a scale is a key aim of this workstream and SMART objectives are currently being co-designed which will help increase system resilience.

1.	To continue dialogue with PCNs and Place Board regarding access to same day urgent primary care.	Q2, Q3 & Q4 - 2022/23
2.	To identify and review current activity, flow and build a picture of capacity and demand	Q3 - 2022/23
3.	Gap analysis to ensure national specifications are commissioned	Q2 & Q3 - 2022/23
4.	To agree with partners the same day urgent primary care transformation plan across BLMK and present proposals for implementation.	By 31st March 2023

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

Making sure the most vulnerable receive the care they need in a co-ordinated and planned way is enabled significantly utilising personalised and proactive care from a named clinician. We have embedded the principle of continuity of care in the BLMK Fuller programme and there is aligned clinical leadership from a range of clinicians working as part of multi-disciplinary neighbourhood teams. The work of the PCNs is crucial in improving patient outcomes and reducing inequalities.

As an initial priority, the PMO team have helped to 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 outcomes. In partnership with Local Authority colleagues and the partners of the respective 'Place Boards', we will consider how schemes can enable neighbourhood and place teams. A high-level snapshot of this mapping is illustrated in appendix B.

1.	Map current multi-disciplinary team arrangements by PCN that support frailty and complex care in BLMK	Q2 & Q3 - 2022/23
2.	Develop vignettes of current arrangements to demonstrate the potential/opportunity – what does good look like	Q2 & Q3 – 2022/23
3.	Use PHM data to articulate the opportunity to provide personalised care and support to those at risk of adverse outcomes in each PCN	Q3 & Q4 - 2022/23
4.	Map (proactive care) delivery against the national specification for anticipatory care in BLMK and identify/share current good practice	Q3 - 2022/23
5.	Identify the system support required for MDT working using PHM data and PCN priorities – establish dialogue with partners regarding MDT resource and models for delivery.	Q4 – 2022/23

2.4. An ambitious and joined up approach to prevention

Primary Care including Primary Medical (GPs), Community Pharmacy, Dental and ophthalmology all have an essential role to play in preventing ill health and tackling health inequalities.

Following a meeting with the two Directors of Public Health, the initial priority agreed was to work with GP Practices and Community Pharmacists to (i) maximise the offer and take up for Covid and flu vaccinations and an all age immunisation workstream, (ii) facilitate access to and the offer of cancer screening, health screening, case finding of CVD for long term conditions, (iii) delivery of the NHS Long Term Plan (LTP) tobacco dependency programme and digital weight management programme, (iv) embedding PCN inequalities priorities in Place Boards.

The ICB's work associated with Core20plus5, has also been mapped and a future 'prevention' paper is proposed to be developed with the Directors of Public Health.

1.	Establish partnership working with staff Public Health teams and staff in the ICB to design a local approach for place based prevention plans. Support the four place Boards to work with system partners especially CVSC achieve this	Q2 &Q3, - 2022/23
2.	To map PCN inequality and prevention plans with LA Public Health plans to collaborate to jointly target resources to 'place agreed' priorities.	Q2 & Q3 - 2022/23
3.	Assess variation across PCN populations of low health screening rates, low immunisation rates and how prevalence of primary CVD risk factors	Q2 & Q3 - 2022/23
4.	Implementation of agreed 'Place' prevention plans with aligned outcome measures.	By 31st March 2023

Further opportunities

The delegation of the Pharmacy, Ophthalmology and Dental contracting function from NHSE to ICBs from April 2023 brings with it opportunities in relation to place. Although the contracts will remain nationally negotiated, there will be flexibility for us to add locally commissioned services which

deliver services that are aligned to the specific needs of local communities, for example by linking in with neighbourhood teams and improving signposting to local pathways for things like hypertension, diabetes, healthy eating and smoking cessation. It also gives us more influence in optimising the opportunities set out in the national contracts around prevention and the initiatives they are already delivering in relation to addressing health inequalities through working with them as a system partner.

In summary we intend to use our collective expertise to understand what factors lead to poor health and wellbeing and to work together to tackle these together to have greatest impact.

The Health and Social Care Select Committee's report published in October exploring the future of NHS general practice, highlighted that General practice at a national level is operating in an extremely unstable environment, which is negatively impacting the development of PCNs and the ability of primary care to play an effective and meaningful role in their local place and system.

Contrary to this national report, all 23 PCNS in BLMK are actively engaged with their respective Place Boards and Bedfordshire Care Alliance (BCA) and the MK senior Leadership Team.

Although BLMK has proportionately less GPs per head of population we are recognised regionally as implementing local and innovative solutions to attract and retain local GPs and to we are also very proactive to develop training PCNs to build multi-disciplinary health and care teams around PCN populations.

3. Ensuring a system approach to maximise collaboration and connectivity

The BLMK Fuller Programme aims to facilitate and enable the Place Boards to shape and work with our communities and partners to develop neighbourhood teams.

The comprehensive programme plan will be available by the end of November and is being constructed to provide a monthly report that can be categorised by place and workstream.

Appendix A is an illustration of the programme arrangements and system connectivity.

The Primary Care Commissioning and Assurance Committee (a Subcommittee of the Board) will have oversight of the BLMK Fuller Programme.

The BLMK Fuller Programme is supported by both the ICB Fuller Programme Working Group and a BLMK Fuller Stakeholder Collaborative Group. The Terms of Reference for these groups are currently being finalised with partners.

- The ICB Fuller Programme Working Group will track progress, resolve any escalation issues, and facilitate system connectivity.
- The BLMK Fuller Stakeholder Collaborative Group aims to champion and inform the system programme enabling and embedding place-based transformation.

The critical enablers including workforce development, data analytical support, digital support to neighbourhoods, estates are supported by teams in the ICB.

The first meeting of the BLMK Fuller Stakeholder Collaborative Group is due to meet in December. This collaborative approach will ensure maximum impact for place.

The ICB PMO and Programme Team are currently pulling together the high-level programme plan to capture key objectives and milestones. The outline for this is provided at Appendix B. It is recognised that as the programme develops over the coming months details of interdependent schemes may change.

4. Recommendations for the Board

The Board is asked to:

1. Note the proposed BLMK Fuller Programme approach and progress.

BLMK Fuller Programme – Collaboration & Connectivity

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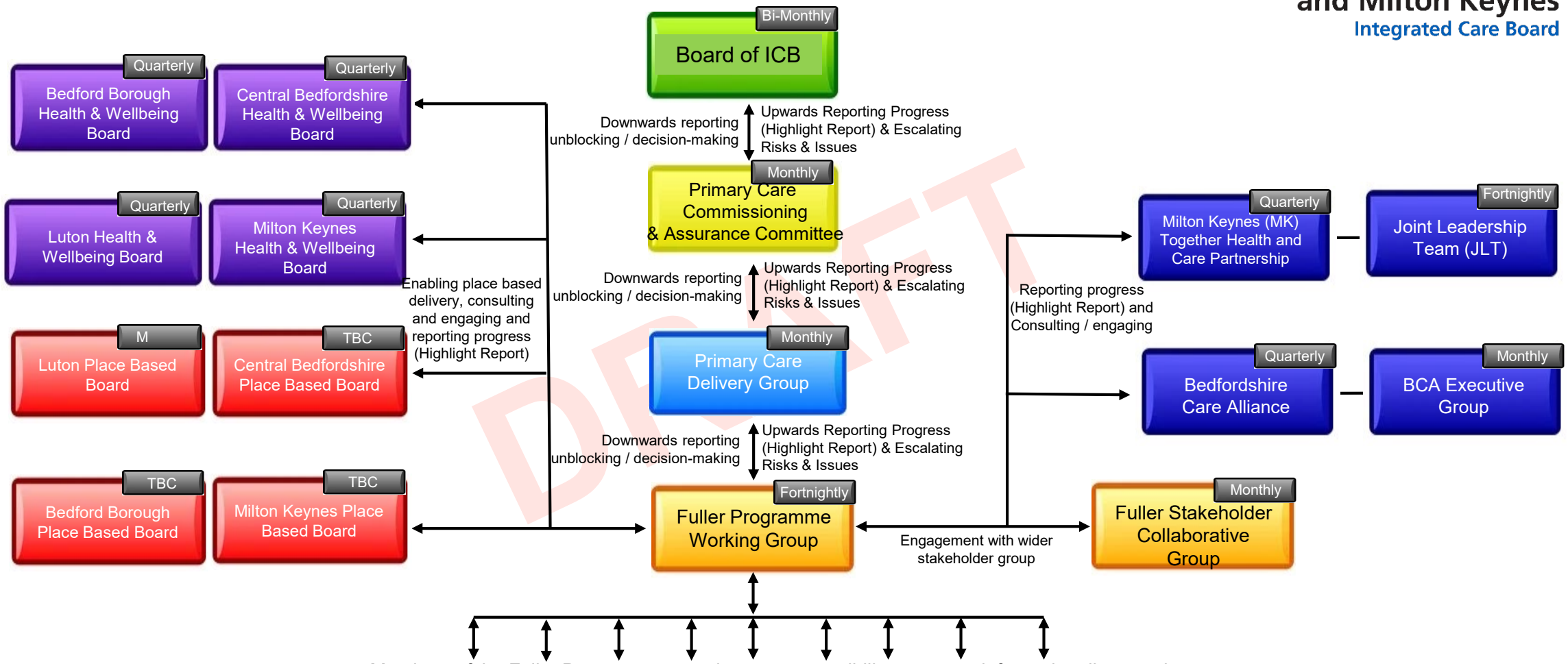

Members of the Fuller Programme team have a responsibility to ensure information discussed within the team is appropriately disseminated to interested or influential stakeholders/groups. Equally members also have a duty to feed information back into the Fuller Programme Team from any interested or influential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

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Report to the Board of the Integrated Care Board
11. ICP Strategy and ICB Operational Delivery Planning Update – November 2022

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.
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☒	**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	Anne Brierley, Chief Transformation Officer, ICB
Date to which the information this report is based on was accurate	15th November 2022
Senior Responsible Owner	Anne Brierley, Chief Transformation Officer, ICB

The following individuals were consulted and involved in the development of this report:
This briefing builds on the discussion at the ICB Board Development Day on 4 November
This report has been presented to the following board/committee/group:
N/A

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

1. **Note the proposed approach to development of this first ICP Strategy** in the context of NHS England (NHSE) requirements, timescales to deliver and wider operating constraints
2. **Approve the key actions and timescales for completion identified for Place / Collaborative / Neighbourhood teams** to ensure explicit triangulation between the overarching aim to improve health inequalities and outcomes against the practical delivery plans outlined in the 2 Year Operational Delivery Plan

Executive Summary Report

The purpose of this briefing is to update BLMK Integrated Care Board on development of its mandated Integrated Care Partnership (ICP) Strategy, publication of the first iteration of which is required by December 2022, and how this will be aligned with the requirement to produce the 2 Year Operating Plan for the ICB by March 2023.

The proposed approach for BLMK outlined below aims to find a pragmatic course through the inherent tensions between immediate term requirements to address the current Local Authority (LA) and NHS significant operational challenges to delivery with the medium-to-long-term ambitions to reduce inequalities and improve health outcomes for BLMK residents.

This paper outlines:

- How business as usual (BAU) operational planning cycle will be co-ordinated and aligned with integrated planning for Place and Collaboratives, with a consistent focus on impact to inequalities and improving health outcomes;
- How the ICP strategy will be used to test and assure the expected impact and co-production with local communities for our plans; and

The briefing highlights the risks to completion of these requirements within the proscribed timescales and offers mitigations to support timely delivery.

1. Brief background / introduction:

The uncertainty in the wider operating environment (global, political and fiscal) means that volatility in core operating functions such as energy, inflation / cost of living is a significant ‘known unknown’ in our planning. This reinforces the need for our ICP Strategy to hold us to our ambition of improving inequalities and health outcomes whilst our operational plans will need to be nimble and adaptable to withstand the competing pressures felt across the public sector.

There is also recognition that the ICB 2 Year Operational Plan will require explicit detail on how NHS partners will deliver the mandated objectives and policy implementation, whilst LA partners will retain their own planning governance processes, but that these will need to align for the specific Place and Collaborative Plans.

Building on the discussions at the ICB Board Development Session on 4 November 2022, this briefing provides the next iteration of how BLMK will:

- Use our business-as-usual (BAU) planning cycles together with our innovative ICB delivery models (Place, Neighbourhood teams and Collaboratives) to optimise short-term delivery and benefit to our residents within all the pressures and constraints of our operating environment; and

- Draw on the expertise of the ICP and the ICP Strategy to provide initial review of impact of Plans to tackle inequalities and improve health outcomes during Q4 2022/3 and Q1 2023/4

The briefing outlines:

- Additional clarifying detail from NHSE on expectations of this first ICP strategy, especially given the short deadlines to complete;
- Clarity on the role of the ICP in utilising this strategy in development of the 2 Year Operational Delivery Plan to be completed by March 2023; and
- Risks to completion of the ICP Strategy and ICB 2 Year Operational Delivery Plan, and suggested mitigations.

2. Summary of key points:

2.1 Context

The NHSE East of England Regional team have provided the following helpful clarification regarding this first ICP Strategy:

- No formal submission of the ICP Strategy to NHSE required – this reflects its status as an ICP (not solely NHS) document, though ICBs must publish and share with all partners their initial ICP Strategy by the end of December 2022;
- There is flex in the scope of the ICP Strategy to allow local focus and format dependant on Integrated Care Board maturity / configuration; and
- The key focus for NHSE in this planning round will be on the 2 Year Operational Delivery Plan; both to test robustness of delivery of mandated NHS objectives and the extent to which Delivery Plans reflect the strategic ambitions of the ICS, as outlined in the ICP strategy.

The NHS Confederation informal webinar on 9th November similarly indicated that ICBs are taking a local and pragmatic approach to developing this initial ICP Strategy. The webinar had NHS and Local Authority representatives from across England in attendance with circa 30% of ICS' represented. The detail of this can be viewed at Appendix 1.

Both these sources indicate that the 'mobilisation' approach to the first ICP strategy for BLMK is consistent with other ICS' and will meet the required approvals.

2.2 ICP 'Mobilisation' Strategy Development Aligned with 2 Year Delivery Planning

The inherent tension between reality and aspiration will be felt most keenly in the relationship between the first ICP Strategy for BLMK and the content and challenges in our 2 Year Operational Delivery Plan. However, ongoing delivery of NHS constitutional standards and LA statutory requirements is fundamental to our 'licence to operate' at a more strategic level to deliver our wider ambitions for our local communities to thrive.

It is proposed that following methodology is embedded in our 2 Year Operational Plan development during Q4 of 2022/3 and Q1 2023/4 to make transparent these tensions and enable conscious decision-making and oversight to achieve the best possible impact for BLMK residents within the existing constraints and pressures:

a. **All Place / Neighbourhood / Collaborative Priority Programmes have clearly defined populations, outcomes measures (i.e., impact on which inequalities and / or health measures) and delivery metrics to assess progress** – this will test the use of resources: resident benefits ratio of transformational programmes, focusing our resources on addressing our most 'wicked' challenges

b. **Reporting against NHS constitutional standards can be viewed through a Place / Neighbourhood / Population cohort lens** – this will keep our focus on the needs of our most vulnerable residents and how we can collaborate to embed prevention / tackle inequalities

c. **An agreed schedule to review existing BAU spend in keys areas of joint delivery against evidence base / best practice to inform recycling of existing resources to deliver strategic objectives** – this will inform the 5 Year Forward Plan, and cover key areas such as community health services, supported discharge from acute hospitals and mental health crisis and recovery pathways

Achieving this will require rapid mobilisation of key enablers:

- The single source of the truth for both delivery of provision and population health management;
- Co-ordinated actions to address 'wicked' workforce and provider market management (i.e., for complex care needs); and
- Adoption of programme delivery at Place / Collaborative with the associated resources aligned.

2.3 Role of the ICP in framing the Mobilisation Strategy & 2 Year Delivery Planning

The Terms of Reference for the BLMK ICP describes its primary objective as the 'custodian of population health management'. For 2022/23 it is proposed that the focus of the ICP is an evaluation of the 2 Year Operational Delivery Plan against the ambitions of the ICP [Mobilisation] Strategy to evaluate:

a. **Do our Place and Collaborative Plans clearly define the health inequalities and health outcomes that will be addressed through local Place, Collaborative and Primary Care Networks Priorities, together with the population health rationale for these priorities?**

b. **Do the Plans credibly describe how we will work with local communities, VCSE and partners to enable use of communities' own assets to co-produce and deliver sustainable impact in tackling health inequalities and improving health outcomes?**

c. **Do the Plans offer credible actions to deliver our ambition to tackle health inequalities and improve health outcomes for all BLMK residents in delivery across our mandated NHS objectives:**
    i. Urgent and Emergency Care, including primary, community and secondary care and mental health?
    ii. Elective Recovery, including uptake of screening, timely access to diagnostics, sustained delivery of cancer standards (especially the 62-day treatment standard) and recovery of long waiters?
    iii. Delivery of mental health, autism and learning disabilities standards of care across all health settings?
    iv. Delivery of the NHSE mandated objectives for maternity, children's and young people?
    v. Implementation of 'Fuller' neighbourhood teams?
    vi. Have explicit strategies to engage and provide appropriate health care to our most vulnerable populations, for example homeless, travellers, LGBTQ+ community, veterans?

During Q4 of 2022/23 and Q1 2023/4, the aim is to draw on the wealth of local knowledge and connections of the members of the ICP to ensure that the 2 Year Operational Delivery Plan has the maximum impact and benefit for our residents. This will build on the feedback from Place and Health and Wellbeing Boards on individual Place Plans to give a pan-BLMK perspective:

- Has anything been missed that will support delivery / impact of the 2 Year Operational Delivery Plan to maximise its impact?
- Are there connections / routes to engagement that will support delivery of objectives with specific local populations?

3. Are there any options?

This proposal is designed to find a pragmatic approach to undertake our 2 Year Operational Delivery planning and the role of the Integrated Care Partnership's contribution to ensure that our operational plans are appropriately focused on tackling inequalities and improving health outcomes for specific populations. This proposal recognises that LA and NHS assurance requirements are different; and current operational pressures mean that we will need to work smartly to bring this together within the required timescales.

To deliver this pragmatic approach within the required timescales, the following enablers / actions will be required:

- Places and Collaboratives will need to clarify their outcomes measures for their priority programmes by December 2022;
- Q4 will require planning to encompass both activity / delivery trajectories for BAU delivery against NHS constitutional standards and LA statutory requirements – AND high-level project plans for Place / Collaborative Programmes;
- 'Good enough' reporting of BAU through Place / Population lens will need to be available from April 2023; and
- Aligned programme delivery (at Place and Collaborative) will need to have agreed methodology and resources aligned in early Q1 of 2023/4.

4. Key Risks and Issues

The speed and scale of these requirements is the most significant risk to delivery. Too hurried and there will be little discernible change to old ways of working to deliver the impact sought; too slow and the negative impacts of current operational pressures will continue to escalate.

Finding the time and 'head-space' for clinical, professional, and operational teams to develop these plans and measures during our current pressures is the most likely single point of failure. The focus will therefore need to start with areas of highest priority which will improve services in the areas which are causing most clinical concern to create the headroom for further transformation work.

The risks associated with timely delivery of the ICP Strategy and 2 Year Operational Delivery Plan are summarised below:

	Risk Description	Initial Risk Score	Mitigations	Target Risk Score
1.	Operational demand pressures in all partner organisations over winter 2022 will limit capacity to develop ICB 2 Year Operational Delivery Plan	20 (5Lx4C)	• Clarity on the planning process and associated approval process – reduce duplication of effort from multiple requests • Use existing meetings to provide engagement and oversight of collective plans • Utilise some ICS staff resource to support the planning process	16 (4L x 4C)
2.	National planning schedules will be delayed, causing uncertainty in planning assumptions	15 (5Lx3C)	• Agree BLMK assumptions via Chief Finance Officers, including worst- and best-case scenarios	12 (4L x 3C)

3.	Contractual and logistical constraints will slow delivery of the 'single source of the truth' for performance, activity, and health population management reporting, limiting our ability to assess the impact of programmes on local population	12 (4Lx3C)	• Agree 'good enough' initial reporting through existing resources whilst allowing time to develop more integrated reporting, i.e., for population health management	9 (3L x 3C)

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

Risks with insufficient mitigation will be added to the risk management system pending the outcome of this Board discussion

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

All Partners will need to release senior capacity to oversee Place / Collaborative Plans as well as BAU operational planning. The Integrated Care System (ICS) will undertake to create capacity to support this process.

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

Click to view Green Plan

Opportunities for efficiencies that also support green plan commitments will be identified through the planning process.

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

This approach by BLMK ICB puts consideration of **impact** (tackling inequalities and improving health outcomes) at the heart of operational planning. It is central to the priorities and actions identified by Places and Collaboratives. As 'custodians' of population health impact, the Integrated Care Partnership (ICP) has a key role to play in challenging NHS and LA partners in the ICB to deliver our plans to maximal impact for residents within our available resources. This includes co-production with residents to shape service delivery, utilisation of communities' own assets to enable them to thrive (including the VCSE) and embedding prevention / secondary prevention along all care pathways.

8. Next steps:

Following approval of these key features of the 2 Year Operational Planning Process for Q3 and Q4 2022/3, Place and Collaboratives will need to:

- Clarify their outcomes measures for their priority programmes by December 2022; and
- Complete their high-level action plans for 2023-4 by March 2023

The ICB will need to ensure that:

- Resources from all partners are identified to support this accelerated planning process, with due regard to LA and NHS assurance processes;
- Due engagement and governance is completed at Place as well as via the Integrated Care Partnership;
- Programme support is identified, and a methodology agreed that supports our commitment to move to a single source of the truth; and
- 'Good enough' reporting of BAU through Place / Population lens will need to be available from April 2023

9. Appendices

Appendix 1 – Summary of 'soft intelligence' from NHS Confederation webinar on ICP Strategy development (2 November) - Below

Similarities to BLMK Proposal	Variances to BLMK Proposal
Overarching audacious goal to tackle inequalities – life expectancy and years lived in good health *Nearly all ICS' in attendance described these as the overarching measure of their ICP strategy's success – noting, however a) the impact of environmental factors on this measure and b) its longitudinal nature*	Role of ICP varied dependant on whether all LAs and health partners were on ICB Board or not *ICBs with a high number of Local Authorities within their patch did not have all directly represented on their IC Board, prompting a differential relationship between the ICP and ICB to those who had all statutory partners as member of their ICB*
Focused on initial ICP strategy as pre-cursor to planning, then mature strategy for 23/24 *This reflects the BLMK Board Development Session (4 November) which reflected the initial ICP Strategy should focus on mobilisation*	Extent of 'blank paper' engagement with local communities on what they wanted for health & care *Those who had completed such exercises reported a significant challenge in reconciling the views of residents with the current pressures and constraints in both NHS and LAs*
Focused on capabilities / capacity / relationships needed to deliver impact on inequalities rather than specific deliverables / expected impact *The latter will be worked up in planning*	Whether a draft of the ICP Strategy had already been published on ICS website inviting comments from residents *This had been undertaken only by a few ICPs, most notably those whose LAs were not all directly represented on the IC Board*
Initial ICP Strategy to be a short public-facing document *Circa 30 pages was cited as the target length*	

10. Background reading

Planning guidance for the NHS is expected in late December 2022.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
12. – Place Based Boards report

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

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

Report Author	Maria Wogan, Chief of System Assurance and Corporate Services
Date to which the information this report is based on was accurate	Maria Wogan, Chief of System Assurance and Corporate Services
Senior Responsible Owner	Felicity Cox, Chief Executive

The following individuals were consulted and involved in the development of this report:
ICB Place Linked Directors
This report has been presented to the following board/committee/group:
This report is a summary of the outcome of Place Based Board meetings in the system,
Purpose of this report - what are members being asked to do?

The members are asked to **note** the issues discussed by the Place Based Boards.

1. Executive Summary Report

1) Brief background / introduction:

As part of the target operating model, and the commitment to subsidiarity, each of the four places in BLMK, Bedford Borough, Central Bedfordshire, Luton and Milton Keynes, has established a board with health, social care, VCSE and Healthwatch partners to oversee service provision, transformation and monitor outcomes for local residents.

The minutes of the meetings are attached as appendices and this report highlights the issues discussed at the recent Place Based board/partnership meetings.

1. **Milton Keynes Health and Care Partnership - 12 October 2022**

a. Joint Strategic Needs Assessment update – key areas of development

- Musculoskeletal Health Needs Assessment had been completed, undertaken collaboratively by the MKCC Public Health Intelligence Team and the ICB. This would drive commissioning going forward.
- Work on the Children and Young People Inequalities and Vulnerabilities chapter of the JSNA is underway, with completion planned by December 2022.
- The chapter on Long Term Conditions and Ageing Well was being scoped.
- The Place Profile for Milton Keynes had been developed.

The Partnership were also informed of the objective to establish a data platform with place specific dashboards.

b. MK Deal

The Partnership agreed the Milton Keynes Deal that had four priority areas with SROs and workstream leads:

- Avoiding unnecessary hospital stays / improving system flow
- Tackling Obesity
- Children & young people mental health
- Support for People with Complex needs

Work on avoiding unnecessary hospital stays and tackling obesity has commenced and will report to the Partnership in February 2023 and development work on the other two priorities will continue, and report to the Partnership in February 2023 for implementation work to commence following the meeting. MK Deal Letter from the Leader of the Council to the Chair of the ICB attached as Appendix A.

c. Milton Keynes Better Care Fund

The statutory return had been submitted and the plan for the forthcoming year was to continue the initiatives in the current year. It was recognised that there was a considerable focus on supporting hospital discharge which was integral to one of the MK Deal priorities.

2. **Central Bedfordshire Place Board - 27 October 2022**

a. Implementing revised palliative care pathways against national guidance, the priority and purpose was to improve experience of all children and adults receiving palliative and end of life care. There was a presentation on the system transformation work in accordance with the National Ambitions Framework.

Business Intelligence Dashboard from birth to death had been developed to evaluate and monitor the existing services, evaluate the impact and outcomes of proposed changes made to existing services, provide accurate and up to date information in one place to help improve services.

ELFT and Sue Ryder provide the end-of-life service in Central Bedfordshire. Engagement with the public was identified as an area of weakness that needs to be strengthened and Healthwatch could support this. It was also identified that Care Home staff required support to build confidence in caring for end-of-life residents, rather than calling an ambulance when the person became unwell.

b. Digitisation of social care

£3m had been invested in digitisation of social care across the four Places in BLMK. This was assisting in the levelling up of digital provision in social care through the digitisation of Social Care Records and work was underway on the connectivity across Care Homes. A further example of the deployment of Raizer chairs, and the use of the Istumble tool that had contributed to how falls are being managed in care homes.

The digitisation gap in the mental health market was identified.

c. Winter Plan

The discussion included the increase in ambulance handover delays, the provision of virtual wards, transparency of data especially as residents in Central Bedfordshire frequently used services outside BLMK and end of life care so the resident could die in their preferred location.

d. Issues that support primary care

There was a presentation on the implementation of the Fuller review recommendations that focused on access to primary care and supported prevention. Areas of note were:

- There had been a 5% increase in appointments in general practice in the year from August 2021.
- Healthwatch identified that residents were reluctant to divulge information on their condition to receptionists and the lack of knowledge that the receptionists were trained care advisers who required the information to enable the person to be referred to the most appropriate clinical professional.
- Cancer screening information was broken down by PCN and surgery and identified areas that could be improved and may require support to do so.
- Due to pressures in primary care smoking cessation targets had not been achieved, however targeted work was being undertaken with anyone pregnant, or with children up to one year and people with a mental health condition.
- How data could be affected by housing growth.
- Covid vaccination uptake will be reported to Councillors more frequently.
- A monthly primary care update would be provided to elected Councillors

e. Emerging issues from Scrutiny

Review of Winter plan in Spring 2023

3. <u>Luton Place Based Board - 11 October and 8 November 2022</u>

a. Place Based profiles

Revised Place based profiles were shared providing rich information on areas of deprivation and areas of focus e.g., identifying hypertension for prevention and treatment. The gap in life expectancy in areas of deprivation to more affluent areas was 20% for men, which had been impacted by Covid. The data would be drilled down to neighbourhood level to provide details of issues that could be addressed locally. The opportunity to work with Central Bedfordshire on areas with similar issues was identified.

b. Children and Young Peoples Plan

A refreshed CYPP was presented to the Board and identified challenges e.g., Covid 19 and the cost-of-living crisis. Preparing for adulthood was identified as a priority area.

c. Integrating Primary Care – Fuller review

The Fuller review recommendations and the four key programmes being implemented in response to these were presented. The importance of including the needs of Children and Young People in the programmes of work and that adult social care has a prevention role, not just supporting hospital discharge was emphasised.

d. Better Care Fund
The Better Care Fund Plan was shared, and it was a continuation of programmes currently being implemented.

e. Emerging issues for Overview and Scrutiny
Mental Health beds
10-year plan.

4. Bedford Borough Executive Delivery Group - 7 November 2022

a. Place based response to the Fuller Stocktake
Following the previous briefing from the ICB on the Fuller proposals, the Primary Care Network Clinical Directors set out their priorities and response to those proposals. These focused on primary care estates, workforce and health inequalities. The Council has also reviewed the proposals and will be attending future PCN CD meetings to discuss services provided. Issues around premises is already a priority area for the EDG.

b. **Developing a local deal for Bedford Borough**
The EDG considered the approach taken in Milton Keynes to develop the MK Deal and whether this was something that could be developed locally. It was agreed that there was scope to continue to look at how this could be taken forward, noting the different structures in this part of the system.

c. **Population Health Management**
Update on recent work with the PCNs to identify the local patient cohort most at risk because of cold homes. Work will start to contact those who are at the highest risk to support them stay warm. Noted the positive work, but intensive nature of the process to identify the cohort.

d. Health Inequalities
Update on the two projects previously discussed which are now agreed to go forward:-

- Warm Spaces – developed list of 'warm spaces' in the borough and continuing to identify
- Sustainability and Resilience Funding for VCSE – aim to go live within the month. This will enable the VCSE to continue to support the most vulnerable in the community through the cost of living crisis and winter.

The minutes of this meeting will come to the next Board meeting.

2) Summary of key points:

As above

3) Are there any options?

None

4) Key Risks and Issues

None

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

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

None to escalate to the Board in this report.

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

Click to view Green Plan

None

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

A focus of Place based boards is to address inequalities for local residents.

8) Next steps:

To report back to the Place Based Boards the discussions at the ICB Board on the issues raised.
To continue to develop the reporting between the Board of the ICB and the Place Based Boards to support system working and effectiveness.

9) Appendices

Appendix A i- Milton Keynes Health and Care Partnership Minutes - 12 October 2022

Appendix A ii – Letter from Leader of MK City Council to Chair of ICB re: MK Deal

Appendix B - Central Bedfordshire Place Board Minutes - 27 October 2022
Appendix C - Luton Place Based Board Minutes - 11 October

Background reading

None

Minutes of the meeting of the HEALTH and CARE PARTNERSHIP held on WEDNESDAY 12 OCTOBER at 2.00 pm

Present: Councillors Marland (Chair), R Bradburn, E Darlington and D Hopkins, M Bracey (Chief Executive, Milton Keynes City Council), V Collins (Director - Adult Services, Milton Keynes City Council), M Heath (Director – Children's Services, Milton Keynes City Council), Dr R Makarem (Chair of BLMK ICB) (Vice-Chair), F Cox (Chief Executive, BLMK ICB), J Hannon (Diggory Divisional Director of Operations, CNWL NHS Foundation Trust), J Harrison (Chief Executive, Milton Keynes University Hospital NHS Foundation Trust), V Head (Director of Public Health, Milton Keynes City Council), Dr N Alam (Representative of Primary Care Networks), C Bell (Deputy Chief Fire Officer, Bucks Fire and Rescue Service), M Taffetani (Chief Executive, Healthwatch Milton Keynes), Supt M Tarbit (LPA Commander, Thames Valley Police), P Wilkinson (Chief Executive, Willen Hospice), J Held (Independent Scrutineer, MK Together)

Officers: M Carr (Deputy Director Public Health, Milton Keynes City Council), D Stout (Development Director, Milton Keynes Health & Care Partnership) and A Clayton (Overview and Scrutiny Officer), Milton Keynes City Council

Observers: R Green (Head of MK Improvement Action Team, BLMK ICB), M Wogan (Chief of System Assurance and Corporate Services, BLMK ICB)

Apologies: None

HCP08 MINUTES AND ACTIONS ARISING

The Partnership considered the Minutes of the Health and Care Partnership's meeting held on 1 June 2022 and noted that all actions from the meeting had been completed or were in the process of being completed, with those outstanding being recorded on the Forward Plan.

RESOLVED -

1. That the Minutes of the meeting of the Health and Care Partnership held on 1 June 2022 be approved and signed by the Chair as a correct record.

2. The actions arising from the previous meeting held on 1 June 2022 were noted. All other actions were completed or in the process of being completed and noted accordingly on the Forward Plan.

HCP09 DISCLOSURES OF INTEREST

None.

HCP10 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

The Partnership received two reports; a) a progress update on the JSNA and b) Milton Keynes Place Profile 2022.

The Director of Public Health presented the report and drew the Partnership's attention to several key points of progress this year:

- Musculoskeletal Health Needs Assessments had been completed, undertaken collaboratively by the MKCC Public Health Intelligence Team and the ICB. This would drive commissioning going forward.
- Work on the Children and Young People Inequalities and Vulnerabilities chapter of the JSNA is underway, with completion planned by December 2022.
- The chapter on Long Term Conditions and Ageing Well was being scoped.
- The Place Profile for Milton Keynes had been developed.

The Partnership heard that the objective was to make the data for the ICB region available on a web based platform, with place-specific dashboards providing key demographic, socio-economic and health indicators. Efficiencies would be achieved through the adoption of the same platform across all councils in the region. Over time it was anticipated that the data would provide an increasingly granular view, allowing for more efficient deployment of public health resources. Disparities in health outcomes amongst different socio-economic groups within the City were made manifest by the data and provided opportunities for appropriate intervention.

The Partnership welcomed the progress made thus far and discussed ways in which the data could be deployed to improve health outcomes. Working collaboratively across the region provided for both a better overview and opportunities for pooling and thereby reducing resources. It was recognised that the JSNA formed the evidential basis on which future commissioning decisions would be made by the ICB in consultation with MKCC, and that, resources being finite, priority should be given to public health initiatives with a strong evidential basis that optimised positive health outcomes for the residents of Milton Keynes.

RESOLVED -

That the reports be noted.

HCP11 FEEDBACK FROM THE BLMK INTEGRATED CARE PARTNERSHIP (ICP)

The Partnership received an oral report from the Chief Executive, BLMK ICB, who identified the following salient points:

- The Integrated Care Partnership for BLMK had now met twice and the focus of discussions to date had been the strategy for the living well priority for children. The ICP was required to formulate clear priorities, whilst taking into account the views and opinions of diverse groups including childcare professionals and members of the general public. The ICP was required by Government to produce the strategy by Christmas this year.
- Whilst the strategy timetable involved working to a deadline, it was more important for the ICP to consider matters in the round in order to arrive at a longer term view.
- The ICP would be meeting next in November 2022.

RESOLVED -

That the oral report be noted.

HCP12 UPDATE ON THE PROGRESS OF THE MK DEAL

The Partnership received an update report on the progress of the MK Deal. The Report was presented by the Chief Executive of Milton Keynes City Council, who provided some background information:

Underneath the Partnership a Joint Leadership Team (JLT) had been formed, comprising representatives from CNWL NHSFT, PCN and MKCC. The JLT met fortnightly to consider in detail how the improvement priorities for Milton Keynes, as decided by the Partnership, might best be met through the working relationship with the BLMK ICB and to bring this together under the MK Deal. The MK Deal is the formal agreement between the Partnership and the BLMK ICB that sets out the arrangements and responsibilities that will operate between the parties to deliver these improvement priorities.

The MK Deal had been agreed with the ICB on 30 September 2022 and an officer had been appointed by BLMK ICB to lead a team on the implementation of the deal in Milton Keynes. One of the key priorities of the implementation was to simplify arrangements and to strengthen the focus on evidence-based solutions, i.e. to focus on key initiatives that were proven to be working well and to cease those initiatives for which the evidence was not strong.

Overall, matters were progressing well. The relationships between the various partners were operating efficiently and the team was

now ready to move forward and put the agreement and plans into action.

The Partnership considered the report and made the following observations:

- That prevention is better than cure, i.e. that the solutions to advancing some of the priorities lay in early interventions, better health education, and the development of strong collaboration with all parties involved in the process, including the voluntary sector, pharmacies and statutory bodies.
- That regarding the hospital discharge policy the plans under consideration would not significantly impact the problems being experienced during this winter season, but the intention was to make improvements in time to alleviate problems during the next.
- That the integrated approach to healthcare offered the potential to improve outcomes across the City. It was hoped that the collaboration required to achieve the four priority areas set this year would strengthen the partnership across the sectors and help build a strong foundation for working together in the future.

RESOLVED –

1. That the MK Deal, as set out in the report, was agreed and a letter sent to the ICB confirming this.
2. That the work on hospital discharge and obesity should start first with a report back to the Partnership at its next meeting on 22 February 2023.
3. That development work on the other two priorities should continue, with a view that the Partnership will agree when these will start at its next meeting on 22 February 2023.
4. That where additional approvals were required to meet the objectives in the MK Deal that these be agreed and actioned by the JLT in consultation with the Chair and Vice-Chair of the Partnership.

HCP13 MILTON KEYNES BETTER CARE FUND (BCF) PLAN SEPT 2022

The Partnership received a report from the Director of Adult Services, who explained that the statutory return was completed and submitted recently and that this report comprised the narrative part of that return.

That the approach and focus of the plan this year was essentially a repetition of the previous year's plan and that no significant changes

had been proposed. The overall spend under the plan was circa. £26 million and had been agreed by all parties, including a range of performance indicators to provide for measurement of success and accountability.

The Partnership considered the report and made the following observations:

- There was a considerable focus on initiatives pertaining to hospital discharge, one of the priorities of the MK Deal. For example, the BCF included funding for a social care team based in the hospital. The use of the BCF provided a model in many ways for the future operation of the MK Deal, involving cooperation between many providers of healthcare in the City.
- That the BCF provided for many services that had become core, essential services. As it was not a fixed fund, but additional monies that were agreed on an annual basis, the Partnership expressed concerned about the reliability of these funds in the future, particularly in the context of possible cutbacks in public sector funding.

RESOLVED -

That the report be noted.

HCP14 INFORMATION ITEM – UPDATE FROM SAFEGUARDING PARTNERSHIP

RESOLVED –

That the report be noted.

HCP15 DATE OF NEXT MEETING

It was noted that the next meeting of the Health and Care Partnership would be held on Wednesday 22 February 2022 at 2.00 pm.

THE CHAIR CLOSED THE MEETING AT 3.22 PM

Leader of the Council

Milton Keynes City Council

Reply to Cllr Peter Marland
Call 01908 253732
E-mail peter.marland@milton-keynes.gov.uk

Dr Rima Makarem
Chair of the Bedfordshire, Luton and Milton Keynes Integrated Care Board

Via email: rima.makarem@nhs.net

9 November 2022

Dear Rima

I am writing to formally confirm that the Milton Keynes Health and Care Partnership (MKHCP) agreed the 'MK Deal' at our meeting on 12 October 2022.

While we all acknowledged that this is just the first step in devolving decision within the BLMK Integrated Care System, it offers a real opportunity to drive improvement in the four priority areas set out within the 'MK Deal'. I know we have a shared belief that making decisions closer to the communities we serve through strong place-based partnerships is key to managing the challenges we face in health and care.

We welcome the initial steps taken by the Integrated Care Board (ICB) to align your resources to support MKHCP to deliver the responsibilities set out in the 'Deal' and your commitment to agreeing a longer-term resource plan with us over the next 12 months.

We discussed the phasing of the implementation of the 'Deal' at the MKHCP meeting on 12 October, noting that we need to agree a timetable for the 'go live' date for MKHCP taking on responsibility for each priority area set out in the 'MK Deal'.

Avoiding unnecessary hospital stays/System flow

We agreed that we want to operationalise the 'Avoiding unnecessary hospital stays/System flow' priority as soon as possible. We propose that MKHCP takes on responsibility for the functions set out in the 'MK Deal' for this priority from 1 December 2022. Following discussion with ICB colleagues, this means:

1. Strengthening the existing approach to the day to day management of the urgent care system in Milton Keynes, including effective management of winter pressures.

2. Developing a longer term improvement plan to deliver functionally integrated services between MKUH, CNWL and Milton Keynes City Council, including:

    a. Simplification of existing pathways for care
    b. More integrated workforce to address workforce shortages

c. Planning and delivery of the virtual ward in MK
d. Agreement of shared risk management and other clinical policies
e. Improved interface with primary care services

3. Taking responsibility for design and delivery of services within the agreed scope including all decisions on the deployment of funding for these services and the use of the existing s256 funding for reducing delays in acute discharge and ensuring that more people are supported at home.

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

5. Partners within the MKHCP will commit to provide leadership and staffing resources to deliver these objectives. The ICB will continue to provide the agreed existing levels of input to the work under the direction of the MKHCP.

6. Partners within MKHCP will continue to report on all mandated indicators to ensure transparency of performance and the ICB will continue to support reporting to NHSE as required. MKHCP will use the following metrics to track progress over time and in comparison to other similar areas to measure the impact of our collective action:

    a. Percentage of patients in MKUH not meeting criteria to reside
    b. 78 week waits at MKUH for elective care
    c. Number of 30 minute ambulance handover delays at MKUH
    d. The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
    e. Percentage of two hour Urgent Community Response referrals that achieved the two hour standard

Tackling obesity

We also agreed that responsibility for the 'Tackling obesity' priority will be taken on by the MKHCP from 1 December 2022. Following discussion with ICB and public health colleagues, this means working together to:

1. Review our NHS and Public Health commissioned weight management services to ensure the offer and referral routes are as effective and simple as possible and residents have appropriate access to support to lose weight.

2. Explore new ways to support people to lose weight so that we can provide support to more people - for example through population health management, the use of wearable technology, use of pharmacological therapies, campaigns in schools and primary care, and proactive work to engage people in community clubs, groups and activities.

3. Through our organisations' roles in policy-making and as employers, shape the food and activity environment in MK in order to prevent more people reaching an unhealthy weight in the future. Examples of this include procurement, planning policy, limits to commercial influence over food choices, use of premises, reward of active travel and employment policies.

4. Measure progress over time and in comparison to other similar areas against the following key annual metrics, recognising that the impact of our collective action will be long term:

    a. Prevalence of overweight (including obesity) among MK pupils of Reception age (Source: National Child Measurement Programme)
    b. Prevalence of overweight (including obesity) among MK pupils in Year 6 (Source: National Child Measurement Programme)
    c. Percentage point gap in the prevalence of overweight (including obesity) between the most and least deprived areas, as measured in year 6 (Source: National Child Measurement Programme)
    d. Adult prevalence of overweight/obesity (Source: Active Lives Adult Survey)

For the other two priority areas (Children and young people's mental health and Managing complex needs), we propose that we move to a 'pre-start' development phase and that we update the ICB on readiness to proceed after the MKHCP meeting in February 2023.

We anticipate the scope of the 'MK Deal' will change over time and as we learn from the work in these initial priority areas. We recognise that the ICB is planning to restructure the organisation in order to provide more dedicated resources to support place-based working and we look forward to hearing more about progress in this area when we meet again in February 2023.

I look forward to continuing to work with you and colleagues within the ICB to continue to strengthen our partnership and shared commitment to improving health and care in Milton Keynes and the wider Integrated Care System.

Yours sincerely

Cllr Peter Marland
Chair of the Milton Keynes Health and Care Partnership

cc: Felicity Cox
Maria Wogan

Record of outcomes Central Bedfordshire Place Board Meeting

Date: Thursday 27 October 2022

Time: 12.02pm- 1.34pm

Place: Microsoft Teams

Attendees: -	
Abdullah Khan	Clinical Director (Chiltern Hills PCN)
Anita Pisani	Deputy Chief Executive & Director of Workforce, Cambridgeshire Community Services NHS Trust
Anne Brierley	Chief Transformation Officer, BLMK ICB
Belinda Ekuban	Clinical Director (Titan PCN)
Beth Collins	Head of Primary Care Development and Transformation, BLMK ICB
Celia Shohet	Assistant Director Public Health, CBC
Charlotte Webb	BLMK ICB
Clare Steward	Programme Director (Digital Delivery), BLMK ICS
Diane Meddick	Senior Commissioner for End of Life and Palliative Care, BLMK ICB
John Fitzmaurice	General Manager, Bedfordshire Hospitals NHS Foundation Trust
Joyce Baskerville	BLMK ICB
Julia Mead	Interim Deputy Director & Lead Nurse, ELFT
Julie Ogley	Director of Social Care, Health & Housing
Kamini Patel	BLMK ICB
Nicky Poulain	Chief Primary Care Officer BLMK ICB
Noeleen McLoughlin	BLMK ICB
Patricia Coker	Head of Integration (Health and Adult Social Care), CBC
Patrick Moore	Transformation Lead and Service Manager, ELFT
Richard Fradgley	Director of Integration, ELFT
Roy Boodhun	Clinical Director, Shefford Health Centre (Ivel Valley South PCN)
Sarah Whiteman	Chief Medical Director, BLMK ICB
Shalene Daly	BLMK ICB
Stuart Mitchelmore	Assistant Director, Adult Social Care, CBC
Tammy Angel	Clinical director DME Bedfordshire Hospitals NHS Foundation Trust
Vicky Head	Director of Public Health, CBC
Apologies:	Allison Jones, Joanna Shortland, Lorna Carver, Michelle Bradley, Sarah Ferguson, Sarah-Jane Smedmor, Stephen Price.

No	**Agenda Item**	**Lead(s)**
1.	**Welcome, introductions and apologies**	**Julie Ogley**
	Julie Ogley welcomed everyone to the meeting.	
2.	**Notes of the meeting held on 29 September 2022**	**Julie Ogley**
	AGREED	

	The Minutes were agreed as an accurate record.	
3.	**Implementing Revised Palliative Care Pathways Against National Guidance in Central Bedfordshire**	**Diane Meddick**
	NOTED The Board received a presentation which described the work that had been undertaken to deliver system transformation in accordance with the National Ambitions Framework. This work had been managed within a programme management approach including revised governance and planning arrangements for BLMK/ICS. The priority and purpose were to improve patient care and the experience for all children and adults receiving Palliative and End of Life Care. A Business Intelligence Dashboard from birth to death had been developed to evaluate and monitor the existing services, evaluate the impact and outcomes of proposed changes made to existing services, provide accurate and up to date information in one place to help improve services. In Central Bedfordshire, ELFT and Sue Ryder had been community-based palliative and End of Life services. The weakest area had been identified as the engagement with the public/ constituents. This was an area that needed more focus. The Board commented that Healthwatch could help with engagement. In response to a question, it was confirmed that information was being received from service users and from hospices data sets, as well as a comprehensive dashboard to monitor service delivery. There were nationally set metrics around personalised care and support planning. Telephone advice lines have been set up for staff to access to help keep individuals at home rather than in hospital and training was also taking place. Local metrics were being developed, and if these were failing, they could be addressed. The Board raised concerns with the support given to Care Homes in providing them with the confidence to keep residents at home rather than calling for an ambulance. It was confirmed that there were two lecturers in practice and a workforce and education task and finish group. All the training courses from separate organisations had been brought together in one place and these were all accessible in the portal. Any organisation would be able to access the training. The lecturers could also go out and work within the Care Homes.	
4.	**Digitising Social Care**	**Clare Steward**
	NOTED The Board received a presentation which provided a summary overview of the social care digitalisation work across the ICS, highlighting progress against current digital schemes and emerging opportunities for introducing new care technology/scaling up existing investment. One of the key elements to deliver across all Places at the current time was the levelling up of digitalisation within Social Care. There were four Place Based digital leads and ten projects in place as well as £3m of investment in Social Care digitisation.	

	It was highlighted that work was being started on the Digitisation of Social Care Records and work was underway on the connectivity across Care Homes. Raizer Chairs had been successful in contributing to a reduction in falls in Central Bedfordshire. Most importantly there had been a change in culture. The capacity to engage with the care market had improved over the last 6 months to 1 year, and foundations had been built. High level Benefits would be tracked as part of the programme management assurance process via the ICS Social Care Digitisation Board which would duly report to the ICB Digital Transformation Board. In Central Bedfordshire there was a Data Security and Protection Tool Kit, which had standards that care providers needed to achieve. The majority of the providers had met the standard, although the requirement is a continuing process. The Board raised concerns over the massive digital gap in the mental health care market and asked if mental health was being looked at. It was confirmed that there was some parallel working, but it was not as integrated for mental health at present.	
	AGREED		
	1.	Digitising Social Care to be brought back to the Board in 3 months' time with specific information on Central Bedfordshire, such as challenges, where we are etc.	Clare Steward
	2.	Discussion to take place on the digital gap in mental health and how to move this forward.	Clare Steward/ Richard Fradgley
5.	**Preparing for Winter in Central Bedfordshire**		**Anne Brierley**
	NOTED The Board received a presentation on the Central Bedfordshire Winter Plan Update. In BLMK 4 weeks ago there were six 60-minute ambulance breaches across all hospitals a week and now there are twelve per day. Although waits were not as bad as across other parts of the country, there were still waits. The Virtual Ward capacity for Frailty and Respiratory patients would be increased from the current capacity of 66 beds to 175 beds by December 2022. This increased capacity would also extend to Virtual Ward beds for Cardiology Patients. It was not possible to have a view on capacity across Central Bedfordshire. Work needed to be done with Community Services to develop a broader dashboard to look at this data. One of the challenges would be accessing data from outlying hospitals. The Board commented that there was a lack of transparency around data and not enough visibility on capacity in the care market or with care packages. Emphasis was placed on the importance in making sure there was capacity within the market for End-of-Life Care to ensure people could get to their preferred place.		

	The Board highlighted the need to have a better understanding of where the capacity was within the system for adults and children.		
	AGREED		
	1.	A wider discussion would take place on using resources wisely to ensure people are able to get their preferred place.	Anne Brierley/Diane Meddick
6.	**Issues that Support Primary Care- Review of the Members' Briefing Session**		**Nicky Poulain & Beth Collins**
	NOTED The Board received a presentation on Implementing the Fuller Recommendations, which focussed on access and supporting prevention for the population. Access had been highlighted as the number one issue. There had been a 5% increase in GP appointments for August 2022 compared with August 2021. Communications teams had increased efforts to recruit more staff. It had been flagged by Healthwatch that when people had got through to a GP surgery, they were reluctant to give the receptionist any information. There needed to be greater awareness that staff in reception were care advisers and were there to enable the patient to see the right professional. Prevention • Cancer screening had been broken down by practices and PCNs. There were some variations. Central Bedfordshire as a whole looked great but looking closer there were areas that were lower. Collaborative working was needed where there were issues to target. It was important to identify barriers/ blocks at a local level. The Board did comment that some areas could have had their data affected by the rapid housing growth. • There was still some work to be done on the MMR catchup, mainly due to Covid. • Covid vaccination data was to be shared with elected members more frequently. The Board raised concerns around the performance in Care Homes, as previous rounds had done well. However, it was highlighted that there had been a time lag on the data. The Board commented that due to the pressures in primary care, smoking cessation had not been delivered in the way that it had been previously. The Board were advised that targeted lung health checks had started in Central Bedfordshire, and they included smoking cessation. Targeted work was focussed with anyone pregnant and up to a year after birth and also within mental health services. Following the Health and Wellbeing Board and the Overview and Scrutiny meetings, there was an opportunity for Councillors to have more of a discussion and debate about Primary Care. The briefing session had been		

	really useful, and some actions came out of it. The biggest take from the session was that communication was key. There would now be a monthly briefing going out to councillors provided by BLMK ICB.		
	AGREED		
	1.	Covid vaccination data to be shared frequently with elected members	Nicky Poulain/Craig
	2.	Smoking cessation to be picked up at the Central Bedfordshire Primary Care Network meeting	Nicky Poulain
7.	**Emerging issues for Scrutiny**		**Julie Ogley**
	AGREED		
	1.	Review of Winter Plan in the Spring	Anne Brierley
8.	**Any Other Business** Arlesey General Practice will become a branch of the Larksfield Practice from 1st November following a recent procurement process.		
9.	**Forward Plan/Work Programme**		**Julie Ogley**
	AGREED		
	1.	To be taken offline to discuss dates and any deferred reports.	All
10.	**Date of Next Meeting: Thursday 24 November 2022 at 12pm.**		

Luton at Place Board meeting Tuesday 11 October 2022 3.30 – 5.00
via MS Teams

Present:

Mark Fowler (Chair)	MF	Corporate Director Population Wellbeing Luton Council
Nicky Poulain	NP	Luton Place Link Executive Director -BLMK Integrated Care Board (ICB)
Adam Divney	AD	Service Director Citizen Engagement and Legal Services Luton Council
Sally Cartwright	SC	Director of Public Health Luton Council
Alison Parkinson	AP	Interim Corporate Director Children, Families and Education Luton Council
Kate Sutherland	KS	Programme Manager Luton Council
Michelle Bradley	MB	East London NHS foundation Trust
Nina Pearson	NPe	Clinical Director Lea Vale PCN
Haydn Williams	HW	Clinical Director Hatters Health PCN
Sanjay Sinha	SS	Clinical Director Phoenix Sunrisers
Caroline Cook	CC	Chief Executive Luton All Women's Centre
Lucy Nicholson	LN	Chief Executive Healthwatch Luton
Helen Barnett	HB	Chief Executive Active Luton
Craig Lister	CL	Associate Director BLMK Clinical Commissioning Group (Imms and Vacs)
Beth Collins	BC	Head of Primary Care Development and Transformation BLMK ICB
Mazhar Hussain	MH	Clinical Director Larkside Practice
David Morris	DM	Chief Executive NOAH Enterprises
Christopher Morris	CM	Cambridge Community Services
Matthew Bushnell	MB	Chief Executive Mary Seacole Housing
Manraj Barhey	MB	Clinical Director Medics PCN
Diana Butterworth	DB	Head of Quality Mental Health BLMK Quality Strategic Lead ICB

Presenters

Suliman Rafiq	SR	Public Health Principal Luton Council
Matthew Hudson	MH	Public Health Principal Luton Council
Jade Horsley	JH	Public Health Manager Luton Council

Observers

Paul Lindars	PL	Evexia Health
Sarah Bunn	SB	PCN Manager Hatters Health
Carl Raybold	CB	Beds and Herts Local Medical Committee
Muhammad Wagar	MW	Phoenix Sunrisers
Emma Moorbey	EM	BLMK ICB

Action

1. Minutes, matters arising

The minutes of the meeting held on 09 August 2022 were agreed for accuracy.

2. Inequalities Plan/Warm Hubs – Sally Cartwright/Adam Divney

SC talked through Core20plus5 funding has been allocated across the six clinical areas

- Cancer
- Maternity
- Mental health
- LTC – Hypertension
- Learning disabilities
- Vaccination programme

Action

Full presentation to be circulated for information following the meeting.
BLMK have been allocated £3,197m which is non-recurrent. The funding is intended to help systems to ensure that health inequalities are not exacerbated when seeking cost savings and efficiencies.

Proposed allocation of funds (1)

Project	Description	Allocation	Risks
Immunisations Outreach Support Supporting delivery of immunisations among underserved populations (homeless, rough sleepers and those in precarious accommodations)	Project delivered with NOAH enterprises and Luton council public health team to promote the Flu immunisation and covid-19 vaccination pathway. Includes providing hot meals for clients.	£10,000	TBD
Financial incentives for pregnant women. Supporting pregnant women to quit.	Project will be delivered with Total Wellbeing and Luton Council Public Health team. To: • Support pregnant women who opt into the TWL stop smoking service, • to encourage ongoing engagement with quit support programmes throughout their pregnancy, by offering a financial incentive • Vouchers would be given for initial engagement with a stop smoking specialist Subsequent vouchers are given for biologically validated quits (CO monitored).	£58,000 145 women (50% SATOD) in 20/21 x £400 * Put cap on spend to mitigate against overspend if high uptake	New project for Luton. High demand and over-spend

AD talked through the Warm Hubs model noting the importance of knowing how this links to the evidence which can support residents beyond just coming in and having a cup of tea, making every contact count.
Recommended next steps include:

- identifying the budget
- engaging some of our system partners to provide wrap around services and use of their buildings
- developing a Charter similar to the one in place in Gateshead

Timeline need to launch now with a communications plan. Space at Lewsey Centre has been identified and can be used as a pilot to move forward.

- Test the approach
- Feel connected to others
- Find out what everyone is doing
- Will change and evolve over time

NPe – was in favour of the concept of Warm Hubs and wrap around services but asked about those who are housebound those who are suffering from acrophobia, anxiety and noted the need to think of different population groups.
NPe – noted there are overlaps with work that is already taking place those who are homeless are mostly registered with Lea Vale Medical Practice who have the responsibility to take the vaccinations to them. Vaccinations for children are as important as the adults linking closely with what already is happening rather than two separate pieces of work.
SC – agreed to give consideration to the observation of overlaps and joining up.
AD – agreed there is a need to think about the support to those who are housebound and acrophobic. Mantra is not about heating the house it is about heating the person and ensuring people have the essentials to keep warm at home or away from the home. AD to take this into consideration.
MF – do not want people to feel stigmatised. Think about how people connect into the support available. How to connect to other offers available in the Town.

Action

AP – asked regarding opening times and when can centres become a Warm Hub. Difficulties have been noted around washing and drying and what advice can be given need to think about the dampness with washing and fire safety people using candles to light their homes.
DM – felt Lewsey Community Centre would be a good pilot place assets around the Town available where people may not necessarily know them to be Warm Hubs. Consideration to be given to those in TA and B&B accommodation not only homeless people.
AD – Working Group set up with partners and there is a need to move forward positively.
SB – Hatters PCN are developing a pathway for those who are at potential risk from fuel poverty.
HB – Lewsey Centre starts on Thursday 20 October linked with activities for the Library linked to hot shower facilities at the swimming pool. Warm Hub starting from Monday 24 October four hours a day Monday to Friday. Feedback will be available following the start. Home Library Service could make deliveries of blankets to those who are housebound.
Action:

- Further update at the next meeting — **AD**

3. Sport and Physical Activity Strategy – Jade Horsley/Matthew Hudson

MH talked through the presentation Luton's Sport and Physical Activity Strategy Refresh. Presentation circulated following the meeting for information.
JH noted:

- adopt a whole systems approach
- shared vision
- systems mapping

Vision includes four key areas:

- create active people, stronger relationships in the community
- create active environments target resources in areas of need
- create active systems
- create an active society

Report to the Health and Wellbeing Board. There is a Strategic Steering Group with four sub groups

- active people
- active environment
- active systems
- active society

Each will have an action plan to deliver on.
Timeline

- Consultation in the next month until December
- Analysis of the results in January with amendments made to the Strategy as necessary
- Second phase consultation early 2023 complete analysis with the aim for the Strategy to be adopted late Spring.

Board members to provide any further feedback to MH and JH directly.

4. Social Prescription – Suliman Rafiq/Donna Holding/Emma Stevens

SR – talked through the Social Prescription presentation circulated for information.
Room 1 Mark, Sally, Helen, Adam, Kate, Caroline, David, Matthew, Suliman, Helen, Lucy
Room 2 – Michelle, Nina, Nicky, Baz, Emma, Carl, Paul, Sarah
Room 1 discussions included:

- Funding
- Monitoring
- System
- Alignments
- Next steps

		Action
	Suliman to develop the feedback from each group for further discussion at the next meeting.	SR
5.	**Any other business** CC – to update on the Voluntary Sector Alliance in Luton with the Integrated Care Board at a future meeting.	
	Tuesday 08 November 2022 3.30 – 5.00 Please send agenda items for the meeting to Jane.glenister@luton.gov.uk	

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
13. Developing a BLMK Mental Health, Learning Disability & Autism Collaborative

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):	Co-production Population Health Management Business Intelligence		

Report Author	• Richard Fradgley, Director of Integrated Care & Deputy CEO, ELFT • Ross Graves, Chief Strategy & Digital Officer, CNWL • Anne Brierley, Chief Transformation Officer, BLMK ICB
Date to which the information this report is based on was accurate	24 November 2022
Senior Responsible Owner	• Richard Fradgley, Director of Integrated Care & Deputy CEO, ELFT • Ross Graves, Chief Strategy & Digital Officer, CNWL • Anne Brierley, Chief Transformation Officer, BLMK ICB

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

Preliminary discussion on the direction of travel outlined in this paper have taken place with Bedfordshire Care Alliance, Milton Keynes Health & Care Partnership and place-based partners.

This report has been presented to the following board/committee/group:

n/a

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

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

A) That the direction of travel outlined in this paper be developed into a full proposal for further consideration with Integrated Care System partners.

B) That we explore whether the programme can gain 'accelerator' status with NHSE's provider collaborative programme.

1. Brief background / introduction:

The BLMK ICS Mental Health Programme has grown and matured over the last several years. Across ELFT, CNWL, other providers and the CCGs/ICB, we are currently working with an unprecedented level of collaboration, transparency and trust.

This paper sets out a high-level approach and timeline to build on current arrangements with the development of a Provider Collaborative for all-age Mental Health, Learning Disability and Autism across BLMK.

Subject to approval from BLMK ICB we will move into a more detailed planning and design stage, having carried out initial engagement with system partners during Quarter 2. The programme is targeting achieving shadow running, subject to appropriate gateways, in April 2023.

2. Summary of key points:

2.1 Across ELFT, CNWL, other providers and the CCGs/ICB, we are currently working with an unprecedented level of collaboration, transparency and trust: we have a "one team" approach across commissioners and providers, testing new more blended ways of working with commissioning expertise embedded into providers. As a consequence, we are delivering on improved outcomes, quality and value for residents of BLMK in a number of areas that have previously been "stuck".

2.2 We believe that formalising our currently informal way of working across commissioners and providers, and developing and extending our collaboration more deeply across the ICS, our alliances, and our Places will allow us to make progress more quickly, and develop an integrated approach to whole population planning and delivery that includes prevention through to complex care. We also believe there is an opportunity to more effectively organise our system interface with the East of England Mental Health Collaborative, to promote improve pathways and better outcomes for people who require specialised services.

2.3 Our aim is to work together through a Provider Collaborative for Mental Health, Learning Disability and Autism, to improve outcomes, quality, value and equity for people with, or at risk of, mental health problems in Bedfordshire, Luton and Milton Keynes. Our initial vision, which we will seek to further develop with input from service users, patients and system partners, puts patient and service user voice and a focus on place at its heart, refocusing our efforts on addressing inequalities and unwarranted variation, and working at scale where it makes sense to do so.

2.4 Subject to endorsement from the ICB, over the remainder of this year we propose to develop a full proposal which creates an operating and planning environment that integrates expertise across the BLMK system that delivers the best possible outcomes for our residents. Subject to appropriate gateways and agreement this would enable BLMK to move into a shadow running period from April 2023.

3. Are there any options?

Formal options analysis will be developed as part of planning and design stage, subject to receiving mandate to progress from ICB today.

4. Key Risks and Issues

A full risk assessment and mitigation plan will be developed and included in the full proposal.

There are risks to not proceeding with the direction of travel – on outcomes, quality and value for the population of BLMK, as this would mean the momentum we believe we can build would not be capitalised upon.

There are risks associated with the design process, in particular with regards to ensuring the design of a new operating model genuinely grasps the opportunities of the 2022 Health and Social Care Act and subsequent guidance and is sufficiently thorough to understand the detail and implications of all corporate and programme functions and how these are potentially delivered in future across the System.

There are risks associated with mobilisation, in particular with regards to ensuring mental health is fully integrated into whole population planning in the relevant ICS, alliance and place-based decision-making fora.

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

Will be added once fully developed.

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

Under the proposals the delivery of all mental health investment and planning would be delegated by the ICB to a Committee of the ICB with Collaborative partner members, supported by a partnership agreement. This would include funding for all-age mental health, learning disability and autism (excluding Continuing Healthcare), budgeted at £222m during FY 2022/23. The two Trusts would carry the functions associated with the delegation into the Milton Keynes Health and Care Partnership, the Bedfordshire Care Alliance and the Bedford, Central Bedfordshire and Luton system executives, to ensure an integrated approach to whole population planning and delivery that includes prevention through to complex care.

As part of our detailed design work we will consider how financial arrangements and procedures can be incrementally delegated to ensure a safe transition that mitigates against undue risk. This will include agreement of an approach to funding methodology to ensure that risk and gain is appropriately managed between partners.

Proposals have the potential to include changes to how and where within the system commissioning functions are delivered. Detailed design work will determine which elements of the ICB responsibilities, systems and processes would be delegated. It is proposed that a detailed process of due diligence is undertaken to provide evidence that there is a clear picture of the people, and where appropriate property, liabilities, risks and issues that the collaborative would be receiving upon establishment.

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

Click to view Green Plan

As part of the detailed design work the Collaborative will consider how the ICB and ELFT and CNWL Green Plans can be supported through the proposed Collaborative and Programme.

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

The ICS Mental Health Programme already has an Addressing Mental Health Inequity workstream and is taking forward specific initiatives as part of the ICS Inequalities Programme including the Core20plus5 priority to improve physical health checks for people with serious mental illness. With a refreshed focus on planning and delivery at Place as part of our proposed structures and way of working, we will be able to make faster progress with working with Local Authority partners, VCSE, General Practice and other partners to understand and tackle inequity.

8. Next steps:

Subject to an agreed mandate from BLMK ICB, next steps are to:

- Expand the direction of travel laid out in this paper into a full proposal
- Explore an expression of interest to become an NHSE accelerator site for provider collaborative working
- Target the move to a shadow running phase for the provider collaborative from April 2023, with a test and implement phase during Quarter 1 of FY 2023/24, moving to full live shadow running from Quarter 2.

9. Appendices

Appendix A – Overview proposal

10. Background reading

N/A.

1. Introduction

The BLMK ICS Mental Health Programme has grown and matured over the last several years. Across ELFT, CNWL, other providers and the CCGs/ICB, we are currently working with an unprecedented level of collaboration, transparency and trust: we have a "one team" approach across commissioners and providers, testing new more blended ways of working with commissioning expertise embedded into providers. As a consequence, we are delivering on improved outcomes, quality and value for residents of BLMK in a number of areas that have previously been "stuck". For example, since 2018/19 we have:

- Over 1000 more pregnant women and new mothers receiving perinatal mental health care and new maternal mental health services to support people who have sadly lost their baby or had a miscarriage
- New community crisis teams for children and young people, and much greater capacity in our CAMHS services to support children, young people and their families
- Plans to open a new BLMK wide inpatient ward for children and young people at the Luton Centre for Mental Health in January 2023 – for the first time children, young people and their families will not have to travel far out of BLMK for a bed when they are in crisis
- Six new mental health in schools teams, supporting hundreds of pupils and teachers and plans for five more over the next 18 months
- Treating more adults with anxiety and depression in primary care talking therapies than ever before, 1500 more people now being offered treatment, compared to three years ago
- Early intervention services that are the best quality in the whole of the East of England (as per national 2022/23 EIS audit)
- Embarked on the most ambitious programme of transformation of community mental health services in 20 years, building new community teams around neighbourhoods, working in a much more integrated way with GPs, the voluntary sector and social care, with a real focus on broader psychosocial support, connecting people to communities, supporting more people into work and offering more physical health checks than ever before (approximately 4,500 in Q2 2022/23 compared to around 3,000 in Q2 2021/22)
- New crisis pathways, with access to crisis support via 111, crisis teams that can visit people in their own homes as an alternative to hospital (almost) 24/7, new crisis cafes and more to come this year, and mental health teams in our acute hospitals
- If you live in BLMK and have symptoms of dementia, you are more likely to have a prompt diagnosis than anywhere else in east of England
- Work to develop prevention initiatives well underway through the prevention concordat with local authorities, and a well-developed suicide reduction partnership and plan
- Over £56m since 2018/19 of new investment into mental health services in BLMK.

2. Developing a Provider Collaborative for Mental Health in BLMK

Provider Collaboratives are groups of providers who agree to work together to improve one or more care pathways for their local population. National guidance, published as part of the suite of documents to support the implementation of the Health and Social Care Act 2022 requires mental health providers to be part of one or more collaboratives. Provider collaboratives should aim to:

- Reduce unwarranted variation and inequality in health outcomes, access to services and experience
- Improve resilience by, for example, providing mutual aid
- Ensure that specialisation and consolidation occur where this will provide better outcomes and value
- They may also work with ICBs to take on responsibility for the budget and pathway for their given population. The recently advertised NHSE accelerator programme for provider collaboratives explicitly seeks to provide examples of provider collaboratives taking on delegation for commissioning functions.

In BLMK, we have been informally testing many of these ways of working through the ICS mental health programme over the last few years. We believe that formalising our currently informal way of working

across commissioners and providers and developing and extending our collaboration more deeply across BLMK ICS, our alliances, and our Places will allow us to make progress more quickly, and develop an integrated approach to whole population planning and delivery that includes prevention through to complex care. Some of the specific areas where we believe we can make progress more quickly include:

- **NHS Long Term Plan (LTP) delivery**: whilst we have made much progress against NHS Long Term Plan and Mental Health Long Term Plan delivery, we still have some challenging areas that we believe we can deliver on better together. We also want to ensure that Learning Disability and Autism receives the same level of focus as the transformation of Mental Health services
- **Workforce**: we currently have approximately 500 vacancies in the mental health workforce across all providers in BLMK, which again we believe we can plan for more effectively together
- **Children and young people's mental health**: we will re-model our care offer in light of demand pressures, fragile services, and grasping the huge opportunity to develop NHS Tier 4 beds within BLMK
- **Accommodation care pathway**: in line with the national policy focus on health and housing, and guidance to ICBs including East of England ADASS, working with Local Authority partners and housing providers to define and develop accommodation care pathways including registered care, supported housing and general needs accommodation for people with mental health problems and learning disability & autism, managing the market across health and social care
- **Population health management**: using Population Health Management (PHM) to drive focus on the opportunities to achieve the triple aim for people with mental health problems and physical health co-morbidities, in particular through working more closely with Acute Trust partners and General Practice through the Bedfordshire Care Alliance and the Milton Keynes Health & Care Partnership
- **Prevention**: working with Council partners to design and deliver joined up prevention plans that explicitly tackle inequity in access and outcomes for our communities and focus on our Marmot commitments to tackle the social determinants of health
- **Urgent and emergency care**: working with system partners to address the challenges of increased patient demand and acuity in our urgent and emergency care system, ensuring that patients are supported in the best environment for their care
- **Specialised services**: there is an opportunity to more effectively organise our system interface with the East of England Mental Health Collaborative, to promote improve pathways and better outcomes for people who require specialised services
- **Sustainability**: our existing arrangements are based around relationships between key people and are potentially susceptible to destabilization due to its lack of formality. We could also deliver financial sustainability for mental health services across BLMK.

3. Our vision for a BLMK Mental Health Collaborative

Our aim is to work together to improve outcomes, quality, value and equity for people with, or at risk of, mental health problems, people with a learning disability and people with autism across Bedfordshire, Luton and Milton Keynes.

We propose to develop a proposal for collaboration which will:

- Ensure that our work to plan and improve mental health outcomes is done with the best expertise and evidence and in full collaboration between service users and carers, communities, expert clinicians, care professionals, voluntary sector and academic partners
- Refresh and revitalise how we plan, deliver and hold ourselves accountable for mental health outcomes, quality, value and equity in our Bedfordshire Care Alliance, Milton Keynes Health and Care Partnership and our place-based partnerships, and in particular involving service users, carers and citizens
- Refocus our effort on driving down inequalities across our communities in BLMK. This means focusing more on underlying causes and targeted support to ensure services are based on the needs and assets of people across BLMK, and not constrained by geography

- Taking our cue from the pandemic response, focus on collaboration and partnerships, reimagining the commissioning of the future with Local Authority partners – with commissioning functions at scale and place delivered in a much more integrated way with providers
- More effectively organise our system interface with the East of England Mental Health Collaborative, to promote improve pathways and better outcomes for the population of BLMK
- Reach collective decisions about how to best use our resources to deliver outcomes at scale and at place. We will focus on reducing duplication, improving efficiency, and looking outward to those we serve.

4. Initial design principles for a BLMK Mental Health Collaborative

Following preliminary discussion with ICS partners, we believe operating principles for a BLMK Mental Health Collaborative would include the following:

We would aim to create stronger partnerships across the ICS, in our alliances and in our places that better enable how we plan, deliver and hold ourselves accountable for mental health outcomes, quality, value and equity. Service users and carers and citizens will be much more squarely involved in both the design of new programmes and in holding us to account for delivery.

Mental Health Partnerships in each borough would take responsibility for developing and delivering local plans, informed by a deep understanding of the needs and assets of the local population, and local priorities established by the Health and Wellbeing Board and borough-based executive. Local partners including VCS and general practice will be central, with a significant opportunity to join up the commissioning of the future across the NHS and Councils.

For Bedfordshire, a key relationship is with the Bedfordshire Care Alliance, where the Mental Health Collaborative would connect in order to ensure whole population planning across programmes and across the whole Bedfordshire population.

Across the ICS, we will build on our existing ICS-wide programmes to promote pan-ICS improvement and learning.

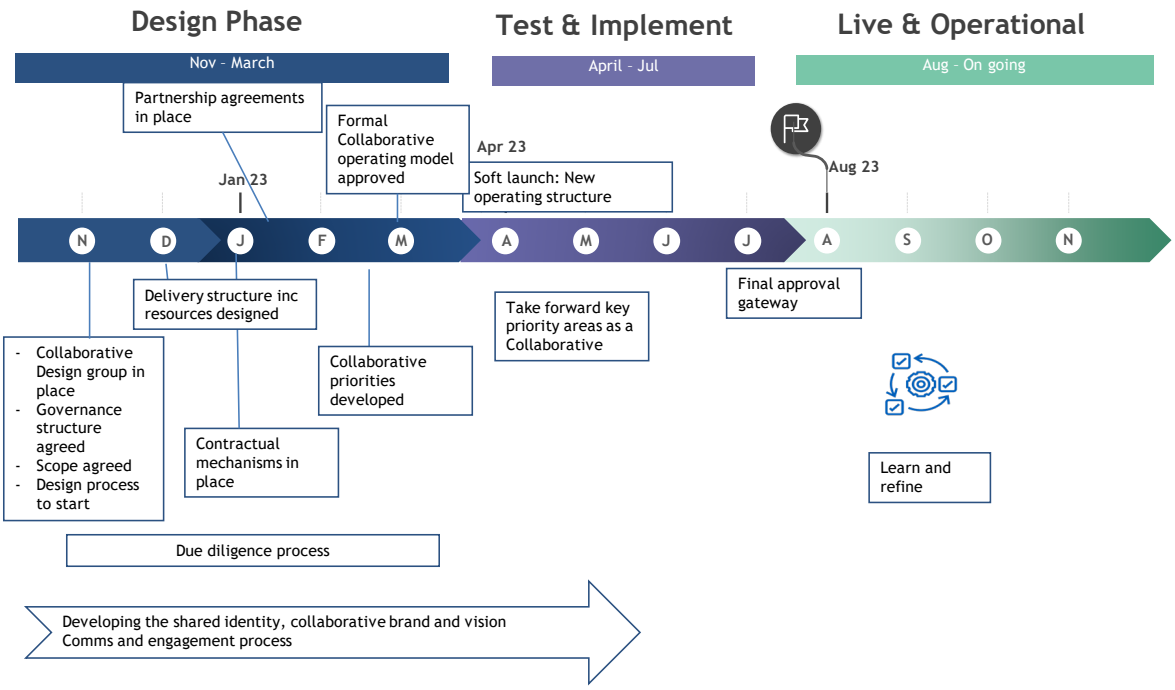
A Committee of the ICB would be formed to oversee the work of the Collaborative. Under the proposals the delivery of all mental health investment and planning would be delegated by the ICB to the Committee of the ICB with Collaborative partner members, supported by a partnership agreement. This would include funding for all-age mental health, learning disability and autism (excluding Continuing Healthcare), budgeted at £222m during FY 2022/23. The two Trusts would carry the functions associated with the delegation into the Milton Keynes Health & Care Partnership, the Bedfordshire Care Alliance and the Bedford, Central Bedfordshire and Luton system executives, to ensure an integrated approach to whole population planning and delivery that includes prevention through to complex care.

5. Indicative development roadmap

Subject to an agreed mandate from BLMK ICB, next steps are to:

- Expand the direction of travel laid out in this paper into a full proposal
- Explore an expression of interest to become an NHSE accelerator site for provider collaborative working
- Target the move to a shadow running phase for the provider collaborative from April 2023, with a test and implement phase during Quarter 1 of FY 2023/24, moving to full live shadow running from Quarter 2.

The following schematic sets out a high-level roadmap for our proposed development programme.



NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
14. Report of the Independent Investigation into East Kent Maternity and Neonatal services **" Reading the Signals" Dr Bill Kirkup CBE**

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	Anne Murray, Director of Nursing
Date to which the information this report is based on was accurate	27/10/222
Senior Responsible Owner	Sarah Stanley Chief Nurse

The following individuals were consulted and involved in the development of this report:
Local Maternity and Neonatal System
This report has been presented to the following board/committee/group:
Local Maternity and Neonatal System

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

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

1) Contents of the published report
2) LMNS response to further working
3) Progress report planned for early 2023

Executive Summary Report

1. Brief background / introduction:

This report provides an outline of the findings of the independent investigation of the Maternity and Neonatal Services at East Kent University NHS Foundation Trust conducted by Dr Bill Kirkup and published on 19th October 2022. (Appendix A)

The report describes how those responsible for the provision of maternity services failed to ensure the safety of women and babies, leading to repeated suboptimal care and poor outcomes. The findings of this investigation were supported by information and evidence gathered through families listening sessions, review of clinical records and interviews with managers, staff and others and external organisations.

The report highlights an unacceptable lack of compassion and kindness, impacting heavily on women and families both as part of their care and afterwards, when they sought answers to understand what had gone wrong. It delineates grossly flawed team working among and between midwifery and medical staff, and an organisational response characterised by internal and external denial with many missed opportunities to investigate and correct devastating failings.

2. Summary of key points:

The origins of the harm identified and set out in the report lie in failures of team working, professionalism, compassion and listening. The report further highlights failures after safety incidents, failure in the Trust's response including at Trust Board level and the actions of the regulator including numerous missed opportunities to rectify the situation that had developed relating to attitudes and behaviour, and dysfunctional team working.

Furthermore, it identifies a clear pattern that those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor.

Overall, the investigation report importantly highlights that the repeated problems were systemic, particularly reflecting problems of attitude, behaviour and team working, and how they reflect a persistent failure to look and learn. This included poor professional behaviour among clinicians, particularly a failure to work as a cohesive team with a common purpose.

BLMK Local Maternity Neonatal System response to date

The Local Maternity Neonatal System (LMNS) has reviewed the recommendations and will work with all partners including the Maternity Voices Partners (MVP) to develop the 4 key action areas. This work will be done in conjunction with ongoing actions associated with Ockendon recommendations, national transformation programme and the Maternity Incentive Scheme.

- Both Trusts are doing lots to support staff following publication as it is a 'hard read' and have invited our midwives to join any support groups they feel may offer support needed.
- Support for new MVP reps, in terms of them managing any queries or questions from women and managing their own feelings around this. LMNS staff are available to help.

- A LMNS workshop Is planned to take this work forward and will report back to the Integrated Care Board in early 2023.

3. Are there any options?

The workshop will consider options for responding to the report in our system.

4. Key Risks and Issues

There is a risk that if we do not learn from this report including all the learning from previous reports, Ockenden etc, and demonstrate our learning through improvements our residents will not receive appropriate quality of maternity care and women and babies could suffer harm as a result in terms of clinical care , patient experience and trust with our maternity services.

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

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

Financial and workforce implications will be considered in developing the response to the report.

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

Click to view Green Plan

Not applicable

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

Inequalities is considered in all our work and will be a focus area in learning from this report.

8. Next steps:

LMNS response via workshop and progress report planned for early 2023

9. Appendices

Appendix A – Summary of the Report of the Independent Investigation into East Kent Maternity and Neonatal services

10. Background reading

Reference

https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report

Report of the Independent Investigation into East Kent Maternity and Neonatal services

" Reading the Signals" Dr Bill Kirkup CBE

Investigation Findings:

A. Assessment of Clinical Care Provided

The investigation identified the following clinical outcomes:

- Had care been given to the nationally recognised standards, the outcome could have been different in 97, or 48%, of the 202 cases assessed by the Panel, and the outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases.

- In the 25 cases involving injury to babies, 17 involved brain damage (HIE and/or cerebral palsy) had care been given to nationally recognised standards, the outcome could have been different in 12 of these 17 cases (70.6%).

- In the 32 cases involving maternal injuries or deaths, the Panel's findings are that in 23 (71.9%) had care been given to nationally recognised standards, the outcome could have been different.

- The Panel has not been able to detect any discernible improvement in outcomes or suboptimal care, as evidenced by the cases assessed over the period from 2009 to 2020.

B. Experience of Families

The wider experiences of the families identified 6 common themes which have been further elaborated by their indicative behaviour:

1. Not being listened to or consulted with:

 Not listening to women's concerns or not taking them seriously, resulting in a failure to recognise warning signs or a deteriorating situation

 Not taking the time to explain to women or their families what was happening or involving them fully in decisions about their care

 Failing to keep accurate notes about what women themselves were saying and how they were feeling

2. Encountering a lack of kindness and compassion:

- Showing a basic lack of kindness, care and understanding to women and their families
- Making unkind or insensitive comments to women and their partners
- Showing an indifference to women's pain

 Failing to ensure or preserve women's dignity or provide for their basic needs

 Placing women with other mothers and their newborn babies following the loss of their own baby or after a serious event

 Putting pressure on families to consent to a post-mortem examination

3. Being conscious of unprofessional conduct or poor working relationships compromising their care:

- Making rude, inappropriate, or offensive comments to women and their partners
- Behaviours or comments that undermined colleagues, including public disagreements, and raising concerns directly with women about their care

 Disagreements between individuals in the same or different professional groups about women's care, including giving mixed messages

 Failing to pass on or act on information, including failing to hand over effectively at shift change or to communicate effectively between services

- Shifting the blame for a poor outcome onto colleagues

4. Feeling excluded during and immediately after a serious event:
 Not being told what was happening, or what had happened, when things went wrong
 Leaving family members waiting and anxious for news

5. Feeling ignored, marginalised or disparaged after a serious event:
 A collective failure to be open and honest or to comply with the duty of candour
 A collective failure to act on or respond to concerns, including a poor or inadequate response to complaints
 A tendency for the Trust to fail to take responsibility for errors or to show accountability
 A failure to provide adequate follow-up support, including appropriate counselling

6. Being forced to live with an incomplete or inaccurate narrative:
 Blaming women and families, or making them feel to blame for what had happened to their baby
- Not giving women and their families answers or reasons for why things had gone wrong

C. Experience of Staff - This helped to shape the investigation findings.

The Four Key Areas for Action identified to be addressed:

Key Action Area 1: Monitoring safe performance – finding signals among noise

A reliable nationally standardised mechanism to give early warning of problems before they cause significant harm. This will monitor the safety and performance of its maternity and neonatal services in real time and will be based on:

- Better outcome measures that are meaningful, reliable, risk adjusted and timely
- Trends and comparators, both for individual units and for national overview
- Identification of significant signals among random noise, using techniques that account properly for variation while avoiding spurious ranking into “league tables”.

Key Action Area 2: Standards of clinical behaviour – technical care is not enough

Technical competence is not enough there is an equal need for staff to behave professionally and to show empathy. There were frequent instances of a distressing and harmful lack of professionalism and compassion and evidence of staff not showing kindness or compassion and not listening or being honest. Staff response had been based on personal and institutional defensiveness on blame shifting and punishment. The well-founded views and concerns of women and other family members were dismissed or ignored altogether they were simply not listened to. This key action area highlights the need to address the balance between the technical aspects and the human kindness needed to care for people compassionately, effectively, and safely.

Key Action Area 3: Flawed team working – pulling in different directions

A team that does not share a common purpose is not a team. The East Kent maternity services was dysfunctional and described as “toxic”, “stressful” working environments. The failure of obstetric staff and midwives to trust and, in some cases, respect each other added a further significant threat to patient safety.

There is a need for a better concept of teamwork for maternity services; one that establishes a common purpose across, as well as within, each professional discipline.

Key Action Area 4: Organisational behaviour – looking good while doing badly

The East Kent Trust prioritised reputation management to the detriment of being open and straightforward with families, with regulators and with others. The problems of organisational behaviour that place reputation management above honesty and openness are both pervasive and extremely damaging to public confidence in health services.

Recommendations:

Recommendation 1

- The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.

Recommendation 2

- Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.

- Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.

Recommendation 3

- Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how team working in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.

- Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, team working and development.

Recommendation 4

- The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.

- Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.

- NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership

Recommendation 5

- The Trust accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
15. Quality and Performance Statement - November 2022

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.
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☒	**Reducing Inequalities:** In everything we do we promote equalities in the health and wellbeing of our population.

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

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

Report Author	Sarah Stanley - Chief Nurse, Maria Laffan - Deputy Chief Nurse, Maria Wogan, Chief of System Assurance and Corporate Services, Anne Brierley – Chief Transformation Officer
Date to which the information this report is based on was accurate	Latest available data as at 14/11/22
Senior Responsible Owner	Sarah Stanley, Chief Nurse and Maria Wogan, Chief of System Assurance and Corporate Services

Executive summary

This paper summarises key areas of quality and performance by exception across the Bedfordshire, Luton and Milton Keynes. The focus is on areas of impact to residents/patients and outcomes, safety, safeguarding and experience.

As an ICB we are working towards a 'single source of the truth' in terms of reporting on quality and performance to enable effective collaborative system working and peer accountability. This is a significant developmental journey for our system in terms of establishing shared data and supporting analytics and capturing all the key elements of system performance including primary care, community health services and social care which are largely absent from this current Board report. For future reports to the ICB, we are aiming to produce a focussed report on positive and negative variance that describes what level of assurance we have as a Board and identifies any unmitigated clinical and operational risks together with actions being taken to rectify the position, together with pan-ICS or mutual aid actions required to minimise risk and support recovery.

The Board report will not duplicate the work of sovereign organisations or place or collaborative working but will focus on the important system-wide issues and risks. This meeting's Board report represents some progress from the previous Board report but there is much work still to do to achieve our aim and the Board can expect to see iterative improvements in the quality of the report over the remainder of this year. Feedback from Board members on what is helpful in the report and what would be helpful in future reports would be very welcome at the Board meeting or outside the meeting.

Included in this paper:

1. New risks to the system and serious incidents/media attention;
2. Complexity and vulnerable people in our system update;
3. Patient Safety (PSIRF) programme update;
4. Safeguarding programme update;
5. System oversight framework;
6. Inequalities programme update; and
7. Quality and performance data – exception reports.

Statistical Process Control Charts (SPC) – time series graphs

SPC charts have been included to demonstrate variation in performance over time. These charts consist of the following:

- Solid black line in the middle represents the mean (average);
- Grey dotted lines represent the control limits or process limits. 99% of data points will fall within these limits. The limits are set by the data based on the variation within it;
- Red dotted line represents a target or a threshold; and
- Grey dots represent each of the data points. The change of colour of the dots indicates an unusual pattern in the data which is statistically significant (also called special cause variation). Blue shows an improvement and orange shows deterioration.

What are the available options?

As described in relation to individual items in the paper.

Recommendation/s

The Board is asked to:

a) **note and discuss** the concerns raised within the report
b) **suggest improvements** for the structure and content of future Board quality and performance reports and
c) **note** that future reporting will be expanded to include:
   - Data related to specific areas for deeper discussion – i.e. children & young people, frailty, end of life care.
   - Cardiac Arrest Rates
   - Falls Rates
   - Pressure Ulcer Rates
   - Safer Staffing aggregated update
   - Celebrating good programmes/improvement work across the system
   - Resident/patient and staff experience
   - Primary care, social care and community health services

Key Risks and Issues

Key risks are included within the report.

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

Risks are identified and included on the quality risk register. A discussion is due to take place at the next Quality and Performance committee in December around consolidation of risks associated with quality and the Board Assurance Framework.

Are there any financial implications or other resourcing implications?

Financial Implications: N/A
ICB Resources associated with this work
ICB Quality and Safeguarding Place Leads and Leadership Team: 12 WTE
ICB Flow Team: 9 WTE
ICB Performance Reporting Team: 4 WTE

All of the above teams work closely with system partners from the NHS and Local Authorities. Key governance groups are the System Quality Group and the Performance and Delivery Group

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

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

How will / does this work help to address inequalities?

Inequalities will be considered in all aspects of transformational work as a part of the quality agenda, considering if communities are affected adversely using the Equalities Impact Assessment Process.

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

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

Next steps:

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

Appendices

Appendix A – Review of Patient Experience on Mental Health Wards in England

Appendix B - BLMK System Oversight Framework Dashboards – October 2022

Link to NHSE Guidance on Single Oversight Framework https://www.england.nhs.uk/wp-content/uploads/2022/06/B1378_NHS-System-Oversight-Framework-22-23_260722.pdf

1. New risks to the System, Serious Incidents and Media attention

1.1. Review of Patient Experience on Mental Health Wards in England

Recent BBC Panorama and Channel 4 Dispatches programmes highlighted serious mistreatment of patients on mental health wards in England. NHS England's National Mental Health Director, Claire Murdoch, has issued a letter to all Trusts and ICBs setting out the expectations to improve patient experience. Both CNWL and ELFT, who provide the majority of mental health and learning disability services across the BLMK footprint, are working up plans in response to the letter to which there is not currently a date set for response and the ICB is undertaking a review of all mental health, learning disability and autism inpatient services, including children and young people and Continuing Healthcare, across BLMK.

Action - See Appendix A for draft report

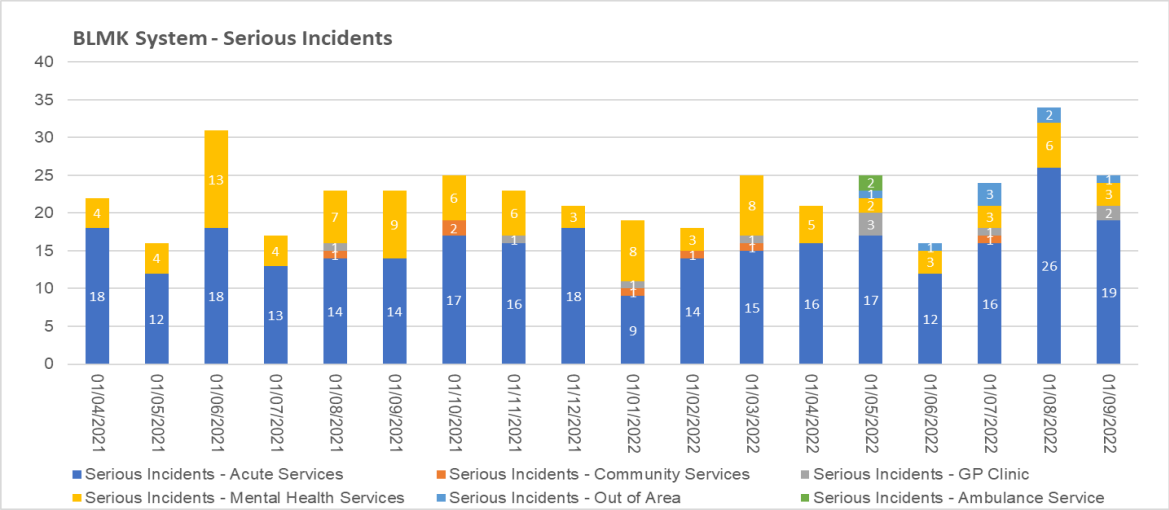
1.2. Ridgeway Lodge – care home (HC-ONE national care home provider)

An incident occurred in a local authority commissioned residential care home for people with Dementia, where one resident was physically attacked by another, resulting in fatal injuries.

Action - Safety visits of all BLMK HC ONE homes have been undertaken by the Quality and Safeguarding teams with an action plan drafted with the local authority care standards team. Support is available for the families of both residents.

1.3. Serious Incidents

The table below shows number of serious incidents and areas where the incident occurred. Two ambulance delay handovers resulting in severe harm and death. New patient safety framework rollout plan and learning from incidents discussed later in paper.



Data Source: Local SI trackers and the national Strategic Executive Information System (STEIS) database

2. Complex and vulnerable people in our system

Mental Health	MIND crisis cafes as part of a system wide crisis offer. Crisis staff working in SCAS control room to support reducing conveyances. Community Mental Health Teams linking with The Hub and SPA

	function. Thames Valley Police - street triage work in shared vehicles to support urgent response to possible mental health patients. **Action - find out how these programmes are progressing and impact**
Learning Disabilities	Increasing uptake and quality of Learning disability annual health checks – see Quality & Performance Data section below. 19/20 – 19.23%, 20/21 27.06%, 21/22 65.89%, **Await 22/23 data**
Children Young People	New eating disorders pathway being introduced to reduce risks. **Action – confirm eating disorder pathway in place and how successful**
SEND Central Bedfordshire & Luton	*Central Bedfordshire* - significant action undertaken to improve experience and outcomes during the covid-19 pandemic. A revisit by Ofsted and the CQC in July identified areas of improvement, which now form an accelerated progress plan. *Luton* –positive revisit by Ofsted and the CQC in October. **Action - awaiting the final report outcome**
Looked after Children Review (LAC) Assessment	All children are assessed, **however not within national standards.** A review of the LAC Model across Bedfordshire and Luton took place in October. GP recruitment to support with delivery is challenging, however, training programme has been developed. Challenges remain in Milton Keynes with delays in receiving consent in a timely manner. **Action - confirm assessment time frames**
Local Maternity and Neonatal Services (LMNS)	Progress continues against Ockenden compliance. Workforce remains the greatest issue in maternity services - regional team is mobilising workforce planners across ICBs. Continuity of Carer plans are on hold with NHSE while issues of workforce are addressed. The ICB is also focussing on addressing recommendations from the recent publication of the East Kent / Kirkup report on Maternity Services. **Action - Kirkup actions to be included with Ockenden compliance – and confirm compliance/gaps**

3. Patient Safety Incident Response Framework (PSIRF) Programme update

The ICB is working collaboratively on implementation of the Patient Safety strategy with the Eastern Academic Health Science Network and the Eastern Region, and has supported its first Patient Safety Specialist network. An inaugural PSIRF workshop is planned in November working across the ICB on implementation of this policy. PSIRF advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement, embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management. The implementation of PSIRF will not be achieved by a change in policy alone it requires work to design a new set of systems and processes. This programme is likely to require additional programme management support.

Action – complete resource paper for PSIRF programme within four weeks for discussion

4. Safeguarding

4.1 Recent publication of a Safeguarding Adults Review focussed on learnings for system partners around Children and Young People transitioning to adulthood. Incidents in our system also confirming this as a theme.

Action - Work is being led by the ICBs Assistant Director for Safeguarding together with system partners including workstreams across the Special Education Needs and Disabilities (SEND) agenda. Update of progress in next board paper.

4.2 Liberty Protection Safeguard (LPS) – Provides protection for people aged 16 and above who are or need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements. This will replace DOLS (deprivation of liberty safeguards).

Action – task and finish group across system to support roll out & education, go live planned Sept 2023

5. System Oversight Framework

The System Oversight Framework (SOF) describes NHS England's approach to oversight for 2022/23. It aligns to the priorities set out in the operational planning guidance and the legislative changes made by the Health and Care Act 2022, including the formal establishment of ICBs and the merging of NHS Improvement into NHS England. The framework will support ICBs and NHS England to work together and develop proportionate and locally tailored approaches to oversight that reflect:

- a shared understanding of the ambitions, accountabilities and roles between NHS England, ICBs, individual trusts and local partnerships, and how performance will be monitored
- the unique local delivery and governance arrangements specifically tailored to the needs of different communities
- the importance of delivery against both the shared system priorities agreed between local partners and national NHS priorities.

This updated framework took effect from 1 July 2022. BLMK ICB is rated SOF 2 out of 4 categories with 1 as the best, which means "on a development journey, but demonstrate many of the characteristics of an effective ICB. Plans that have the support of system partners are in place to address areas of challenge". We have agreed a Memorandum of Understanding with NHSE East of England Region which describes how the regulatory relationship and SOF framework will operate in BLMK during 2022/23. The purpose of the NHS Oversight Framework is to:

- ensure the alignment of priorities across the NHS and with wider system partners
- identify where ICBs and/or NHS providers may benefit from, or require, support
- provide an objective basis for decisions about when and how NHS England will intervene.

The framework is made up of 70+ indicators at ICB and/or Trust level. For BLMK current reporting provided by East of England Region includes SOF indicators and performance for the ICB and the two acute trusts in BLMK (see Appendix B). Work is underway to include SOF performance for Cambridgeshire Community Services, Central and North West London Foundation Trust and East London Foundation Trust. Work is also underway with Regional colleagues to understand the data sources and time period for the indicators as some of the performance reported at Appendix C does not reflect the system's understanding of our current performance. Greater clarity on this will enable a meaningful discussion of system performance which is planned for the next System Oversight and Assurance Group meeting (peer accountability meeting of system chief executives) on 13 December 2022. The outcome from this meeting will be reported to the Board in January 2023.

As a SOF 2 system, the ICB has six monthly formal review meetings with the Regional Director and one of these meetings took place on 7th October 2022. Topics covered in the meeting included strategic development of the ICS including strategic capital and the development of place and collaborative arrangements as well as the forthcoming delegation of pharmacy, optometry and dentistry

commissioning and specialised commissioning together with operational performance in relation to winter, UEC, elective care, quality, workforce and finance. The meeting was positive and the outcome and actions were detailed in a letter from the Regional Director to the CEO of the ICB. The System's SOF rating will be reviewed by NHSE by the end of 2022/23. The process for this has not yet been determined.

Actions:

- **include SOF reporting for all NHS Trusts in BLMK**
- **confirm data sources/time frames for SOF metrics**
- **develop and report improvement plans for SOF metrics as appropriate**
- **discuss at SOAG on 13 December 2022**
- **report progress to next Board meeting**

6. Inequalities Programme Update

7. Quality and Performance Exception Reports

A. UEC deep dive

The BLMK System Quality Group held a quality focused deep dive on the 25th October attended by the majority of partners who came together to share information, intelligence and data around the safety, experience and effectiveness of urgent and emergency care pathways. Each person was challenged to identify one thing that could be done differently or where they could have a different conversation. The regional quality and performance team also attended with the aim of sharing the approach in other systems. Partners were challenged to think about the impact on individuals rather than reporting on existing performance metrics and pathways developments.

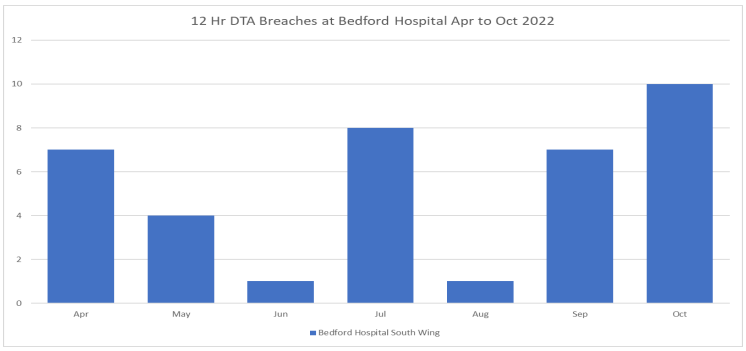
Action – feed themes (below) into change ideas as part of Urgent and Emergency System work

Overview of serious incidents (SIs)	SIs relating to Urgent & Emergency Care Pathway, Ambulance delays and areas such as treatment delays, same day treatment pathways and failure to escalate.
Urgent same day access – self care	Demand and complexity presenting to urgent same day primary care services resulting in poor-quality patient experience.
Step down Beds / avoiding admission / Health care in the home	Enhanced Health in Care Homes Strategy which includes networking, education and quality visits. Liaison between Discharge to Assess teams/Infection Prevention and Control. Covid-19 cases impacting on admissions and discharges. Care homes transient workforce.
Discharge	Poor communication with patients and relatives around discharge planning, management of patient/family expectations with regards to discharge options and pathways. Late day discharges from acute settings, delays in identification of Fast Track patients
Ambulance - EEAST	Underachievement against Category 1 and 2 response timescales, fire and rescue support initiated in Beds locality and now being rolled out trust wide, Arrival to handover best in region at BHT, delays at neighbouring trusts and across region, regional wide support needed, intelligent conveyancing

B. Urgent & Emergency Care Exception Report

There continues to be a rise in demand across acute services and providers remain under significant pressure. All three sites continue to fluctuate between OPEL 3 and 4 with ongoing use of escalation beds, with no signs of de-escalating, and this is having a negative impact on elective capacity. Milton Keynes Hospital spent several weeks at OPEL 4 (but has now de-escalated) with some electives being cancelled and 'boarding' (moving patients between wards) taking place in exceptional circumstances to create flow in the emergency department. However at all 3 sites, ambulance handover delays were significantly less than our East of England colleagues, and none over 4 hours.

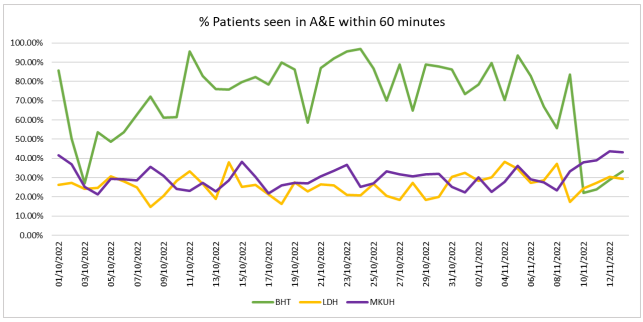
Capacity across all discharge pathways is being utilised but there remains a shortfall in packages of care for long term care, specifically those requiring double-handed care. This results in delays within intermediate care. Flow is maximised through Discharge to Assess (D2A) processes where home is the default discharge destination. Average Length of Stay in all community beds is, overall, decreasing (from 44 days in 2020 to 23 days currently), but we do have significant delays where social care packages are awaited. Out of area patients, mainly from Northamptonshire and Buckinghamshire continue to be stranded in Milton Keynes. During April to October there have been zero patients waiting over 12 hours in A&E following a decision to admit in Luton and Dunstable Hospital and Milton Keynes Hospital however over the same period there have been 12-hour trolley waits at Bedford Hospital. . This is due to the way that Bedford manages its internal flows - see chart below:



Data source: National A&E Dashboard (NHSE/I), updated daily. This data is unvalidated and may be subject to change.

On 22nd May 2019 fourteen trusts, including Luton and Dunstable Hospital, began field testing new emergency care performance standards and as a result these providers are not required to report against the A&E 4 hour wait target. Bedford Hospital and Luton and Dunstable Hospital merged to form Bedfordshire Hospitals NHS Foundation Trust in April 2020 and Bedford Hospital no longer reports against the 4 hour wait target. In October Milton Keynes University Hospital NHS Foundation Trust achieved 79.3% of people who attend A&E are treated/admitted/discharged within 4 hours, compared to the England average of 69.3%.

The percentage of patients seen in A&E within 60 minutes across BLMK during October was 39.55% - 74.11% at Bedford Hospital, 24.54% at Luton & Dunstable Hospital and 28.93% at Milton Keynes Hospital.



Data source: National A&E Dashboard (NHSE/I), updated daily. This data is unvalidated and may be subject to change.

C. Regional/National Requirements of ICBs

Winter Plan and Urgent and Emergency Care Board Assurance Framework

The ICB's Flow team co-ordinated the development of the Winter Plan working with partners across the system. Plans were informed by learning from previous winters and forecasted demand for services across the winter period. "The Next Steps in Increasing Capacity and Operational Resilience in Urgent and Emergency care ahead of Winter" letter set out 6 metrics that NHSE and ICBs will use in each system to provide assurance for the provision of safe effective urgent and emergency care. Latest performance against these 6 and supporting metrics is shown below. The data below is local data from providers and is unvalidated and therefore subject to change.

SYSTEM PRESSURE INDICATORS

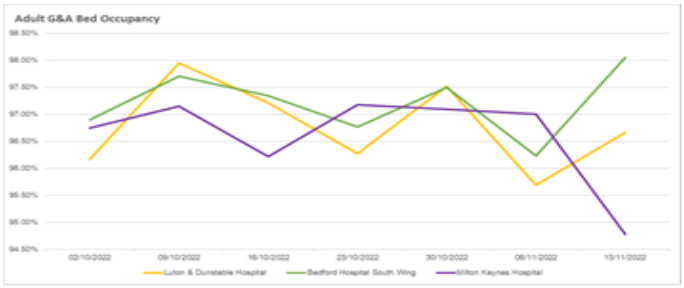
	Latest Data Period	Bedford Hospital South Wing			Luton & Dunstable Hospital			Milton Keynes Hospital		
		Previous	Latest		Previous	Latest		Previous	Latest	
Adult G&A Bed Occupancy - system ambition 92%	14/11/2022	95.43%	97.97%	⇩	96.71%	98.78%	⇩	93.28%	96.64%	⇩
Patients with no criteria to reside with LoS 7+ Days - local ambition 22%	13/11/2022	58.52%	54.51%	⇧	Figures to the left relate to Bedfordshire Hospitals NHS Foundation Trust			82.72%	74.78%	⇧

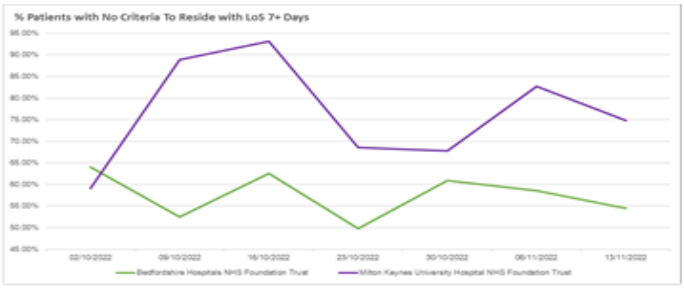
		EEAST - Bedfordshire & Luton						SCAS - Milton Keynes		
		Bedford Hospital South Wing			Luton & Dunstable Hospital			Milton Keynes Hospital		
		Previous	Latest		Previous	Latest		Previous	Latest	
Ambulance Hours Lost to Handover delays (after first 15 minutes) (h:mm:ss)	14/11/2022	12:35:04	11:54:38	⇧	32:16:25	40:25:40	⇩	10:25:22	15:01:48	⇩
Ambulance Mean 999 Call Answering Time (seconds) - ambition 10 seconds	14/11/2022	0:14	0:23	⇩	Figures to the left relate to the Bedfordshire & Luton System			SCAS data not available	0:17	
Ambulance - Category 2 Mean Response Time (mm:ss) - ambition 18 minutes	14/11/2022	42:34	45:56	⇩					28:05	

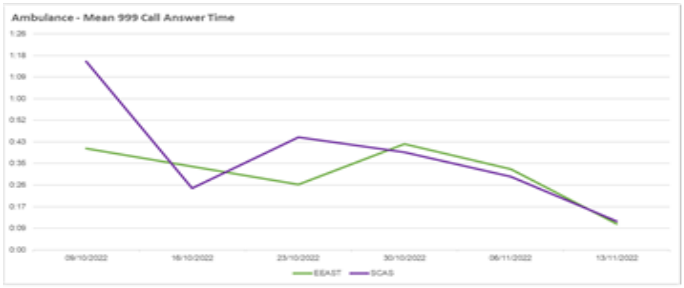
		HUC - Bedfordshire & Luton			DHU - Milton Keynes		
		Previous	Latest		Previous	Latest	
NHS 111 Call Abandonment Rate - local ambition 3%	14/11/2022	12.10%	7.20%	⇧	11.55%	7.10%	⇧

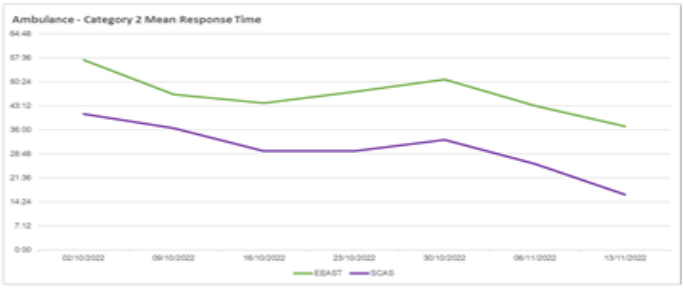
Key:

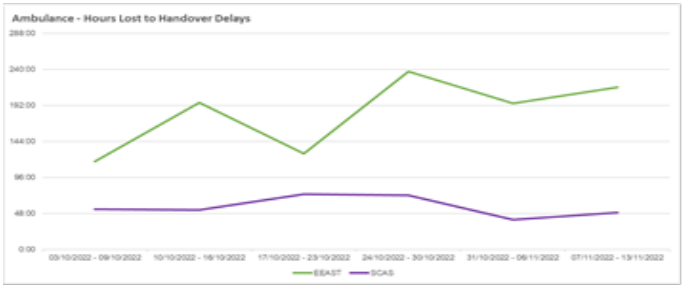
Achieving ambition	
Within 5% of ambition	
More than 5% from ambition	

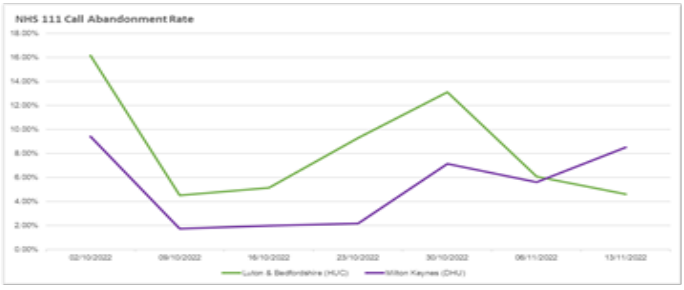












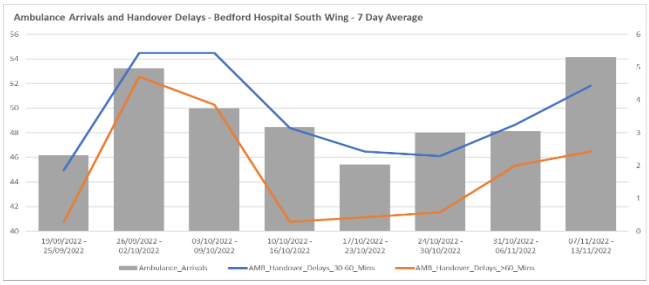
BLMK submitted its Demand & Capacity Plan and draft Version 1 of the Assurance Framework on the 31st August, having been scrutinised and agreed by the Performance & Delivery Group prior to submission. The submission included a self-assessment against 11 domains. The table below shows the BLMK current self-assessment against the relevant domains, showing that 55% of Key Lines of Enquiry, KLOEs are fully compliant, with the remainder to be the subject of our system improvement plans.

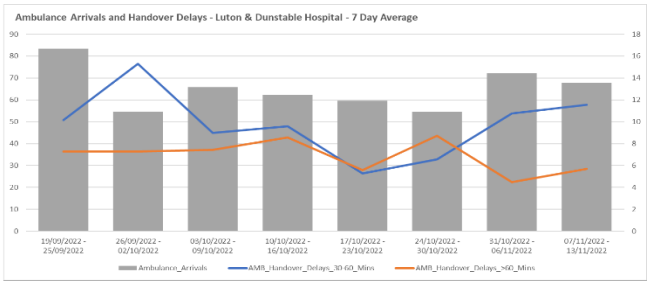
Assurance Framework Domain	Number of KLOES in section	Fully Implemented		Partially Implemented		Planned to be Implemented		Not deemed relevant		Querying with NHSE	
		No	%	No	%	No	%	No	%	No	%
Integrated Urgent Care	4	3	75%	1	25%						
Ambulance	8	3	38%	5	63%						
High Intensity Users	3	2	67%	1	33%						
Alternative Acute & Community Pathways	9	3	33%	5	56%	1	11%				
Emergency Department	16	6	38%	9	56%					1	6%
Treatment in the Emergency Department	13	12	92%	1	8%						
Staffing	8	6	75%	2	25%						
Urgent Treatment Centres	5	1	20%	2	40%						
Flow	6	4	67%	2	33%			2	33%		
Mental Health	9	4	44%	5	56%						
Operational Management & Escalation	5	4	80%	1	20%						
Integrated Care Board	7	3	43%	4	57%						
Totals	93	51	55%	38	41%	1	1%	2	2%	1	1%

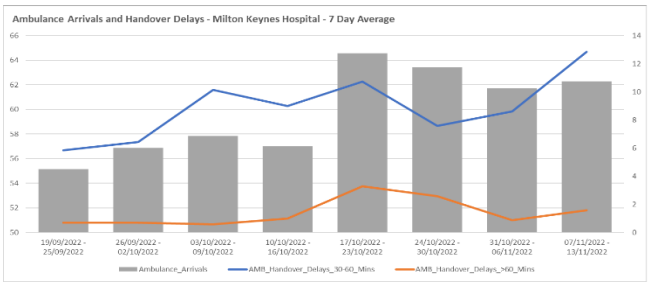
Regional Ambulance Handover Letter

Alongside our Winter Plan, we have developed a BLMK System Ambulance Handover Plan as there is a continuing need for all partners across the ICS to dynamically balance risk across a wider range of system pressures. An area of priority is the provision of timely ambulance handovers to enable the ambulance service to provide a rapid response to critically ill patients within our communities and as a result the 6 metrics above together with a number of supporting metrics are monitored on a daily basis via a local system call. The System Ambulance Handover Plan is also a standing agenda item on both local delivery groups, the Bedfordshire Discharge 2 Assess & Delivery Group and the Milton Keynes Capacity Planning Group. Both meetings take place bi-weekly, and a bi-weekly BLMK highlight report is reviewed and discussed at the fortnightly Performance and Delivery Group meeting.

There is a significant system focus on reducing ambulance handover delays, where performance has worsened in BLMK but is still comparably better than other ICBs in the East of England. A whole system approach is being taken to reduce ambulance handover delays and the position is reviewed at the Performance and Delivery Group and in daily operational meetings in Bedfordshire and MK. BLMK has signed up to a performance target of 30 minute ambulance handover delays and performance is shown in the tables below. MKUH has been commended by SCAS for its performance on ambulance handovers as being the best performer in the Thames Valley area although this may be impacting the Trust's elective performance. For Bedfordshire Hospitals Trust the Luton and Dunstable's performance is impacted by diverts from other areas, 'Intelligent Conveyancing' and on occasion, batching of ambulances and Bedford Hospital's performance is linked to challenge around discharge and flow. A number of new initiatives are underway to mitigate system pressures including the new Same Day Emergency Care unit at MKUH and plans for community services in Bedfordshire to take calls from the ambulance service 'stack' from 16th November. These actions summarise our response to a regional letter requesting ICBs to support system work to improve ambulance handover delays.







Data source: National A&E Dashboard (NHSE/I), updated daily. This data is unvalidated and may be subject to change.

Going Further for Winter Letters

ICBs received a national letter 'Going Further for Winter' which asked ICBs to consider a number of initiatives to manage system pressures over the winter. As a system, via the Performance and Delivery Group we have reviewed our current position and operational approach against the letter to identify our areas of focus which we consider will have the maximum benefit for our residents and these areas and the next steps are summarised below:

Initiative	*Progress and Next Steps*
Support for care homes	Current pathway and provision reviewed in Bedfordshire and MK and feedback loop being put in place to understand and respond to specific areas of variance for conveyances from care homes and higher incidence of falls
Support for fallers	
Community Health Services direct access to the Ambulance 'stack' of calls	Go live in Bedfordshire with East of England Ambulance Service on 16 November 2022. Different approach being taken in MK with South Central Ambulance Service due to different ambulance service system.
Acute respiratory hubs	Clinical meeting chaired by the ICB Medical Director held on 15 November to progress model of care. Follow up meeting scheduled with review of proposal at Performance and Delivery Group on 24 November 2022.
Establishing a System Control Centre from 1 December 202	Clinical risk meeting held in October which agreed to use existing on-call escalation framework to manage clinical risk across the system. System Control Centre will be established by 1 December based on existing on-call model.

Action: continue to develop and deliver winter plans and operationalise System Control centre from 1 December 2022

D. SCAS South Central Ambulance Service - CQC Inadequate rating

The CQC published an Inspection Report in August following an inspection in May. Key concerns around safety and leadership (Safe and well led) which were rated inadequate. The inspection focussed on core service and the Emergency Operations Centre (EOC) provision with particular attention to performance, triage, safety, safeguarding and staff support/freedom to speak up.

SCAS provides ambulance services to the Milton Keynes population. As host commissioner Hampshire, Southampton & Isle of Wight ICB are overseeing the improvement plan, working closely with SCAS as well as Buckinghamshire Oxfordshire & Berkshire West (BOB) and Frimley ICBs on performance recovery. BLMK ICB is meeting with SCAS Head of Operations Emergency and Urgent

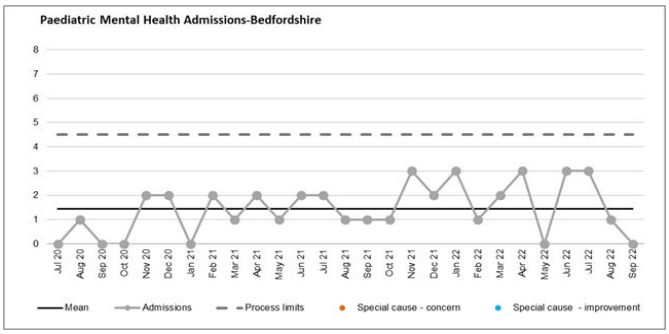
Care for Milton Keynes and Aylesbury Vale twice a month to understand how the trust-wide plan is impacting on BLMK delivery, what may have been identified locally in the CQC inspection and progress against actions to improve the service**.**

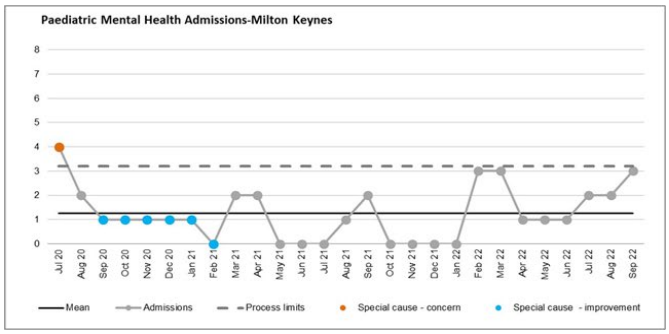
Action – ask for update against action and if any support can be offered

E. Tier 4 provision CAMHS

There is a national shortage of CAMHS tier 4 beds which is also being seen across BLMK and pressure on acute hospital wards to admit young people with complex mental health presentations continues.

A new 8-bed inpatient unit in Luton will provide specialist short-term care for ages 13-17 with severe or complex mental health difficulties and is set to become **operational from December,** however further capacity will still be required to meet current demand. Mental Health and Children and Young People (CYP) leads continue to be involved in national discussions. Additional funding for training and coordination for acute providers to support CYP in crisis is being formalised through contractual arrangements.





Data Source: Inpatient SUS data - provisional data shown for September

F. Elective Care – Exception Report - Referral to Treatment - Long Waits

The ambition is to have zero in system 104+ week waiters and this is being achieved however there continue to be small number of people waiting over 104 weeks outside of the system – chart below Each system leads on the reduction of 104+ and 78+ week waiters with providers (acute and private) within their geography, regardless of which ICB the patient is registered with. Any patients waiting over 104ww in non-BLMK providers are being monitored by the respective ICB and NHSE regional team. The ICB is informed on progress and actions via the wider contract meetings as associates to contracts outside of BLMK area.

Trust	Specialty	Number Waiting 104+ Weeks
Barts Health NHS Trust	Other – Surgical Services	1
Nuffield Health, Cambridge Hospital	Neurosurgical Service	1
Nuffield Health, Cambridge Hospital	Trauma and Orthopaedic Service	1
Royal Free London NHS Foundation Trust	Plastic Surgery Service	1
Saxon Clinic	Trauma and Orthopaedic Service	1
University Hospitals of Leicester NHS Trust	General Surgery Service	1
West Hertfordshire Teaching Hospitals NHS Trust	Trauma and Orthopaedic Service	1
TOTAL		7

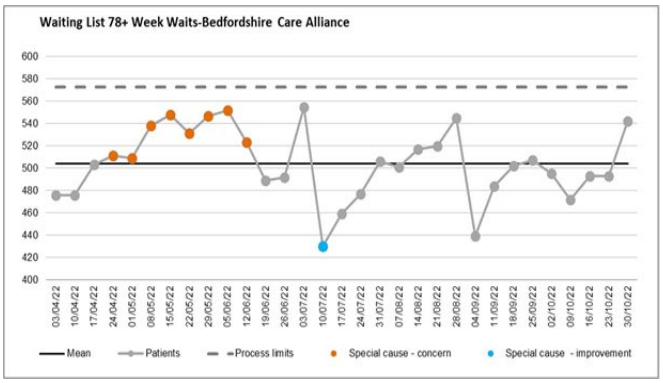
Data Source: Consultant Led Referral to Treatment Waiting Times (NHS Statistics) August 2022, last published 13th October 2022 (monthly publication)

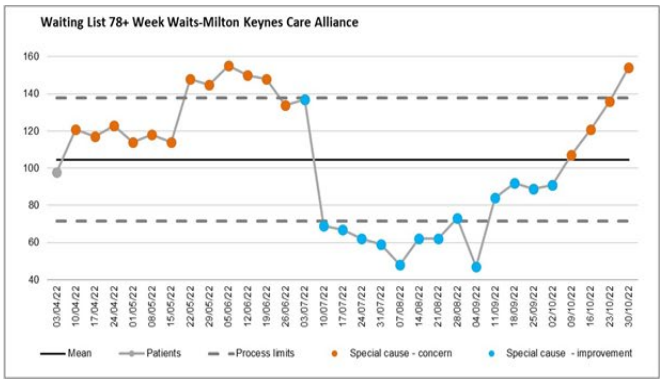
There is a requirement to reduce people waiting 78+ weeks to zero by March 2023 and local providers have agreed a trajectory to achieve this.

The biggest pressure and challenge to achieving the target continues to be in Ophthalmology and ENT across local providers. A recent review with regional colleagues identified potential issues regarding

inequity of Ophthalmology services for residents of Bedfordshire. For 78+ week waiters in Luton 73.45% are within Ophthalmology and for Central Bedfordshire 34.55% are within Ophthalmology with Bedford Borough at 1.77%. In relation to MKUH, performance on people waiting over 78 weeks has deteriorated and there are concerns about data quality which has led to the Trust being categorised as Tier 2 which results in a higher level of scrutiny and support from NHS England. A particular area of concern for both acute providers are the number of people waiting over 52 weeks for a first out-patient appointment in ophthalmology and ENT specialties which we are discussing with providers to understand the underlying risk position.

Action: To deliver against the zero ambition for 78+ week waiters





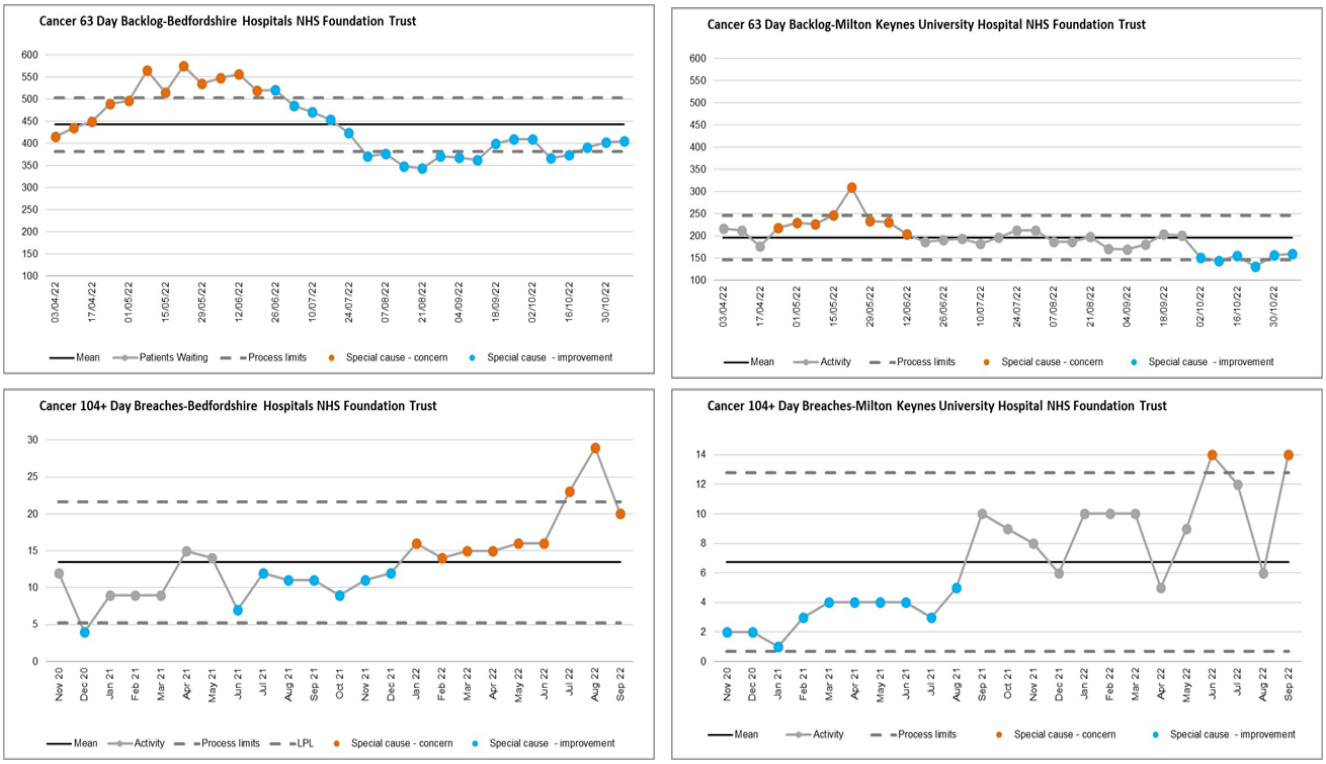
Data Source: National Waiting List Dataset

G. Cancer Recovery

National pressure is increasing around elective care long waits with a particular focus on 62 day and 104 day waits for cancer. Bedfordshire Hospitals remain in Tier 1 despite having made significant improvements to their 62 day cancer backlog position and the Trust is awaiting confirmation that they will be removed from Tier 1 and notification of this is due imminently. As part of the regional assurance on 62 day waiting lists the system set out revised trajectories with supporting action plans to deliver the required reduction in the backlog by March 2023.

The system submitted a plan which included a request for additional funding to support increased imaging and pathology capacity, waiting list initiatives and data analytics support. Impact on some cancer pathways noted in serious incidents due to treatment delays and challenges across diagnostic elements of tumour specific pathways

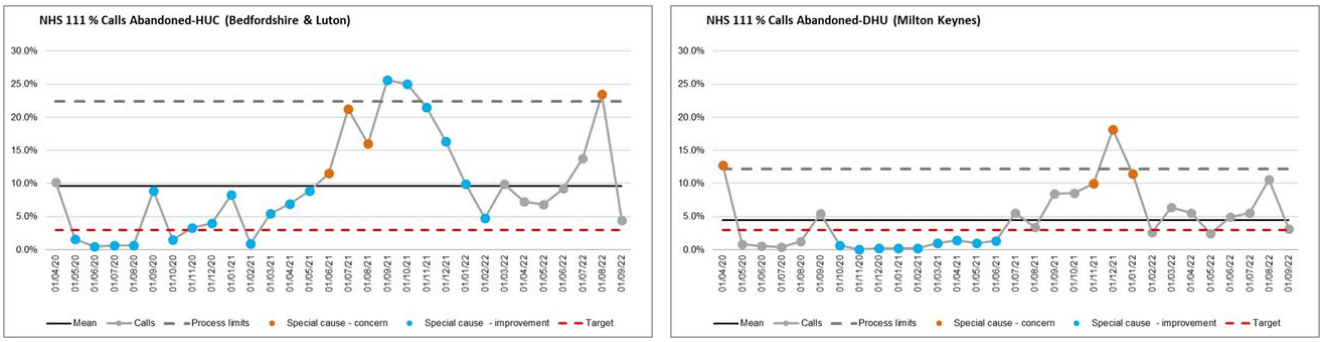
Action – Continue to review plans, risks, and opportunities to accelerate improvements. Awaiting confirmation around the additional funding requests but in the meantime the ICS cancer transformation programme continues to support recovery initiatives. Quality oversight included at Cancer Board following focused worked with teams in provider trust cancer units.



Data sources: Weekly Cancer PTL and NHS Digital Cancer Waiting Times Reports

H. NHS 111 – Abandoned Calls

Due to the Adastra outage in August, the published dataset for August and September is incomplete due to manual recording of calls not all of which were captured in the published dataset. Local data for October collected direct from providers now appears to be in line with normal expected activity and this is showing a high rate of NHS 111 calls being abandoned in Luton and Bedfordshire (Provider: Herts Urgent Care), with 9.8% abandoned and 4.45% in Milton Keynes (Provider: Derbyshire Health United) compared to the national ambition of 3%. There is a risk that patients will not receive appropriate timely primary care leading to increased demand on emergency services. BLMK providers continue to recruit call handling staff and a regional call management centre is being implemented to improve call answering speed and reduce the number of abandoned calls.

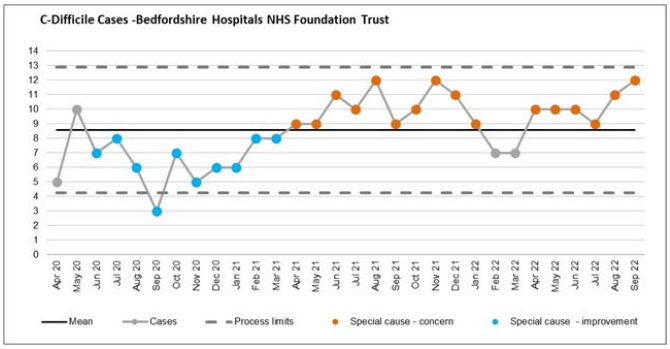


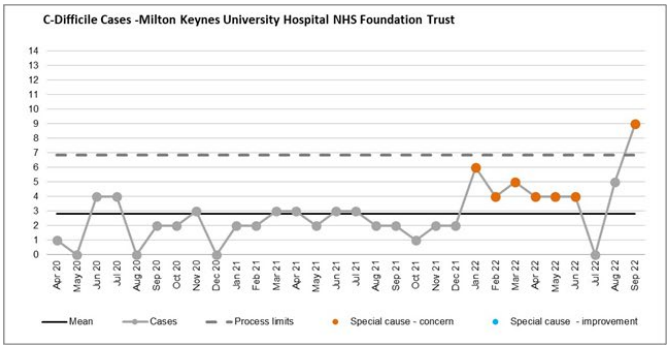
Data source: Integrated Urgent Care Aggregate Data Collection (NHS Statistics) last published 10th November (monthly publication)

I. Infection Prevention and Control

There has been an incidence of Monkey Pox at Bedfordshire Hospitals in September in the gynaecology ward. 22 contacts were identified in both patients and staff. All patients were sent warn and inform letters. No one met the criteria to receive the prophylaxis vaccine and the patient was transferred to Addenbrookes hospital for specialist care. T

here was a norovirus cluster on 2 wards at the Milton Keynes Hospital in September and the incident was resolved on 3rd October.

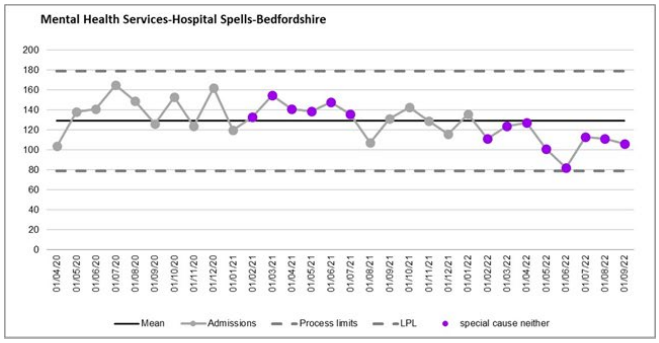


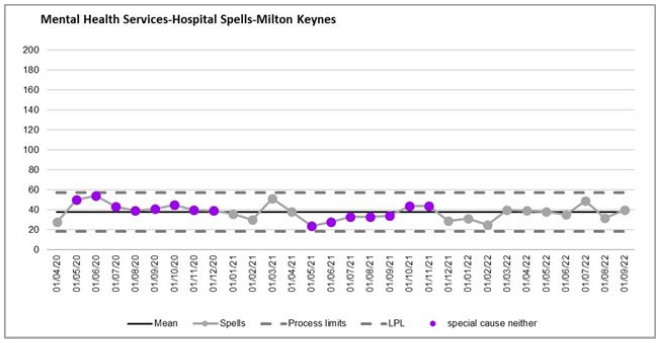


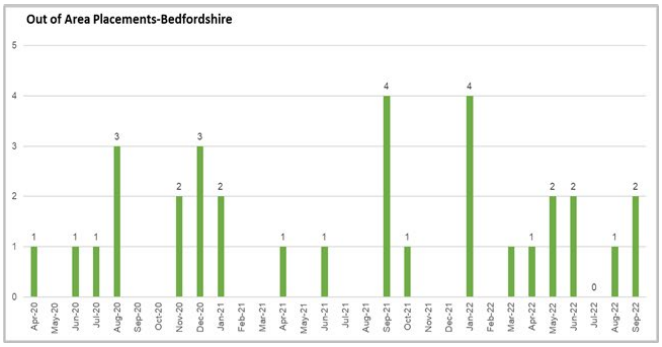
Data Source: C Difficile and MRSA – Public Health England

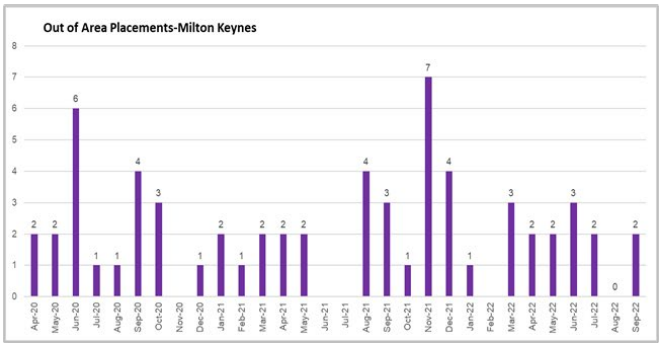
J. Mental Health

Both ELFT and CNWL continue to see very high levels of admissions, and there has been a greater focus on capacity and flow following the 'perfect week' exercise in Bedfordshire. Learning is being shared across the system. CNWL is planning a 'perfect week' exercise for the Milton Keynes system to better understand flow issues.





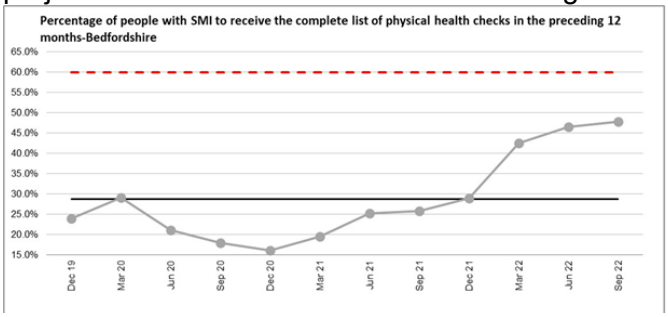


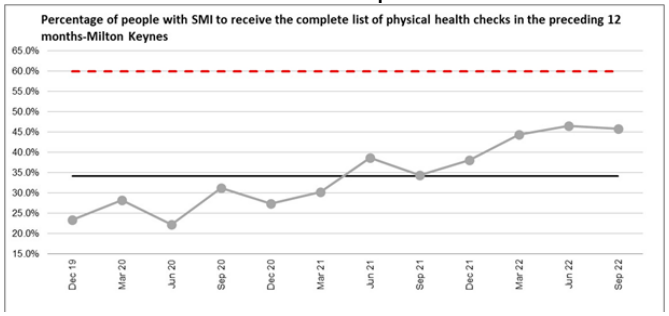


Data source: Mental Health Services Data Set – Provisional data shown for September

K. Serious Mental Illness (SMI) Health Checks

Local data to end of September (Q2) shows performance currently on track to achieve the 2022/23 operational plan by March 23. Key risks across the system are: Non-attendance/declined or no response to offer of health check; competing demands and limited resource to undertake checks in primary care. Discussions are underway with Milton Keynes Urgent Care Service to facilitate outreach projects. Carers in Bedfordshire to encourage carers and their cared for to take up health checks.



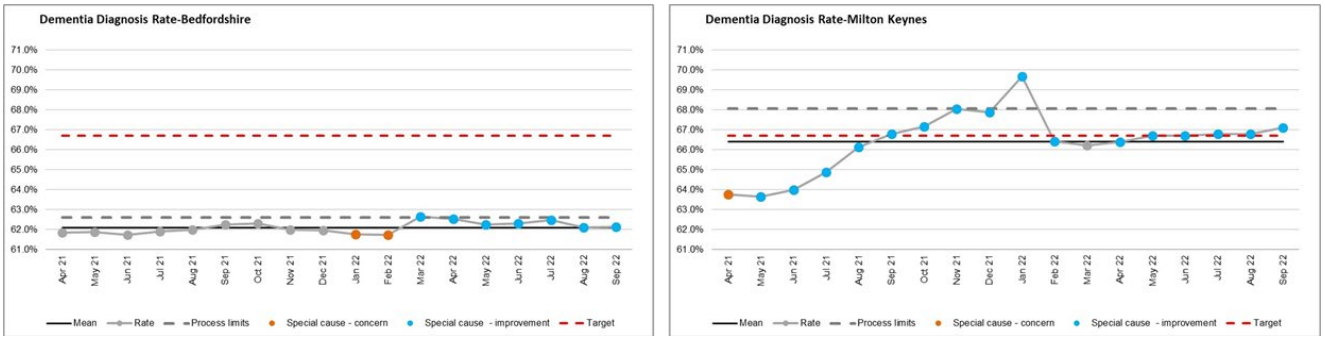


Data source: Physical Health Checks for people with Severe Mental Illness Q2 2022/23 (NHS Statistics), published 10th November (quarterly publication)

L. Dementia Diagnosis

There is a lower diagnosis rate in Central Bedfordshire compared to the rest of Bedfordshire and Milton Keynes. A deep dive has been initiated to review the number of care plans undertaken and anti-psychotic prescribing rates. Funding has been secured for Diadem, a tool for diagnosing dementia in care homes, and staff have been recruited to roll this out initially for one identified PCN. An additional Band 6 nurse has also been recruited in Central Beds and an Advanced Clinical Practitioner (ACP) is working with a GP practice to try and increase diagnosis rate.

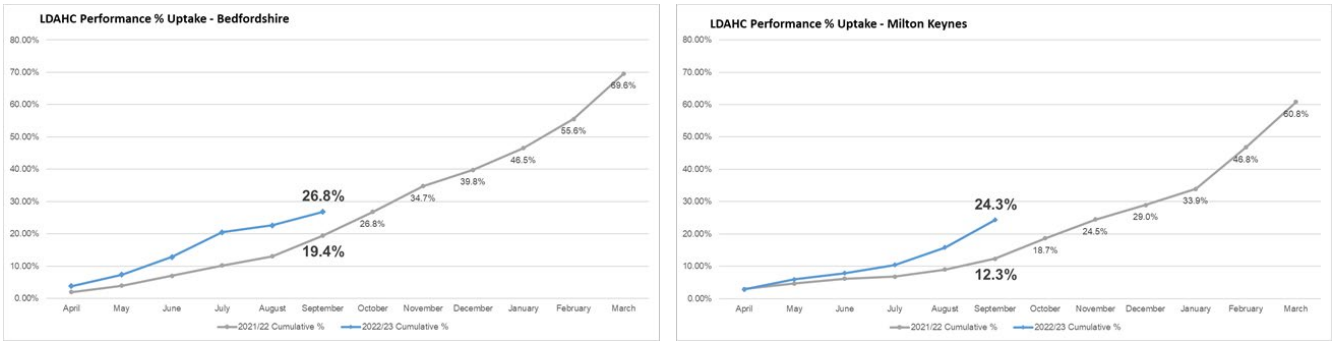
ELFT patient videos are being launched, which will include what to expect at a memory clinic, living well, and post diagnostic support for patient's and carers. A quality assurance piece is underway to ensure all diagnoses are recorded on the GP patient data management system.



Data source: Recorded Dementia Diagnosis, August 2022 (NHS Digital), published 22nd September (monthly publication)

M. Learning Disabilities Health Checks

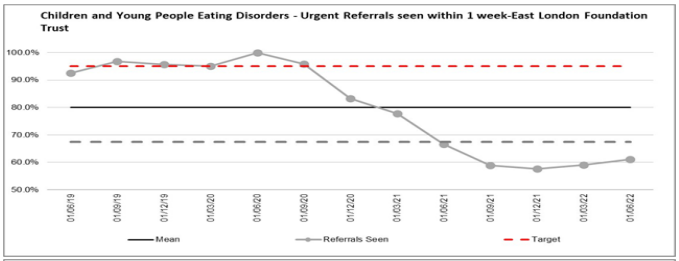
The 2022/23 plan is to deliver 834 Annual Health Checks (AHCs) by the end of Q2 and at the end of August 934 had been completed, with a steady increase in the number of health checks being carried out each month. There is an NHSE initiative to ensure that all patients with a learning disability who did not receive a health check in 2021/22 are invited for a check in quarter 2/3 of this year. Participating GP practices have submitted returns and analysis is currently underway to establish the numbers. A new Project Officer post funded by NHSE for 6 six months is also being appointed to support GP practices with S1 data issues and to improve uptake across BLMK.

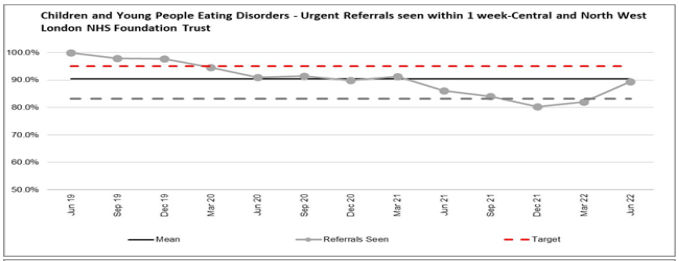


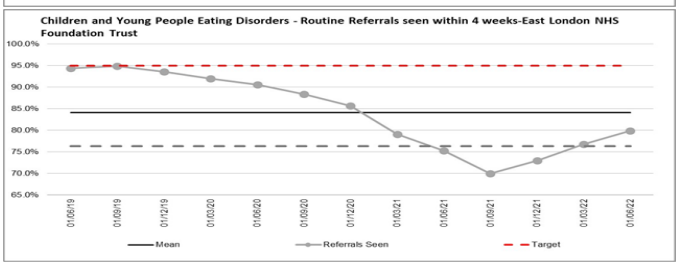
Data source: NHS Digital Learning Disabilities Health Check Scheme, last published 27th October (monthly publication)

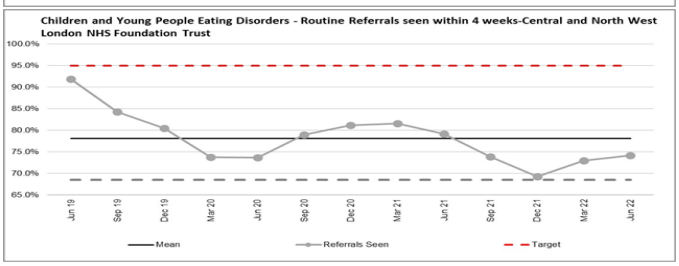
N. Children and Young People (CYP) Eating Disorders

The increased demand seen during the Pandemic has levelled off but remains higher than pre-pandemic. Recruitment has been very positive, and a high intensity team has been mobilised this year and performance continues to improve across the system.









Data Source: Children and Young People with an Eating Disorder Waiting Times (NHS Statistics) Q1 2022-2023, last published 11th August 2022 (quarterly publication)

Month 6 – BLMK Performance Summary Report

Area	BLMK ICB	Threshold	Frequency	Latest Data	Achievement	Trend	YTD	Ranking	Regional Average (ICB position vs region)	What does good look like
Elective Recovery	RTT - % Patients Waiting 18 Weeks or less	92%	M	Sep-22	55.24%	⇩	●	4 / 6	56.47%	High is good
	RTT - Number of 104+ Week Waits	n/a	M	Sep-22	7	⇩		1 / 6	22	Low is good
	RTT - Number of 78+ Week Waits	n/a	M	Sep-22	547	⇩		1 / 6	860.17	Low is good
	RTT - Number of 52+ Week Waits	n/a	M	Sep-22	7,215	⇩		3 / 6	9,010	Low is good
	Diagnostics Tests - 6 Week Waits	≥1%	M	Sep-22	36.23%	⇩	●	4 / 6	35.01%	Low is good
Cancer Care	Cancer -2 Week Waits Standard	93%	M	Sep-22	83.34%	⇧	●	1 / 6	62.10%	High is good
	Cancer - 28 Day Faster Diagnosis Standard	75%	M	Sep-22	70.68%	⇩	●	1 / 6	62.53%	High is good
	Cancer - 62 Day GP Referral	85%	M	Sep-22	58.63%	⇩	●	4 / 6	57.80%	High is good
	Cancer - 104+ day waits	0	M	Sep-22	39	⇔	●			Low is good
Urgent Emergency Care	Ambulance - 30 minute Handover Delays (Daily Average)	n/a	M	Oct-22	21	⇧				Low is good
	% ED Attendances that result in emergency admission	n/a	M	Oct-22	24.61%	⇩			25.30%	High is good
Primary Care	Appointments in GP Practice - % Face to Face	75%	M	Sep-22	78.29%	⇧	●	1 / 6	71.35%	High is good
Adult Mental Health	72-Hour Follow Ups	80%	M	Jun-22	82.00%	⇩	●			High is good
	SMI Healthchecks	Q2: 4300	Q	Q2 2022/23	4,239	⇧	●			High is good
	Dementia Diagnosis Rate	Q2: 64.43%	M	Sep-22	63.50%	⇧	●	1 / 6	59.45%	High is good
	IAPT Access	Q1: 2088	M	Jun-22	2,005	⇧	●			High is good
	IAPT Moving to Recovery	50%	M	Jun-22	48.60%	⇩	●			High is good
	Early Intervention in Psychosis (EIP)	60%	M	Jun-22	81%	⇧	●			High is good
	Inappropriate Out Of Area Bed Days	1054	Q	Q1 2022/23	680	⇧				Low is good
Learning Disability & Autism	Learning Disability Healthchecks	Q2: 11%	M	Sep-22	24.55%	⇧	●			High is good
Children and Young People (CYP) & Maternity	Number of CYP accessing mental health services	Q1: 16,325	M	Jun-22	17,440	⇧	●			High is good
	CYP Eating Disorders - Routine	95%	Q	Q1 2022/23	83.03%	⇧	●	2 / 6	63.17%	High is good
	CYP Eating Disorders - Urgent	95%	Q	Q1 2022/23	78.57%	⇧	●	2 / 6	49.42%	High is good
	Perinatal Mental Health Access	Sep-22: 213	M	Sep-22	55	⇩	●			High is good
Community Services	Children's Wheelchairs - % received in 18 weeks	Q2: 76.32%	Q	Q2 2022/23	73.87%	⇩	●			High is good
	Urgent Community Referrals - 2 hour Standard	70%	M	Sep-22	96.20%	⇩	●		81.87%	High is good
	Urgent Community Referrals - Responses within 2 hours	Sep-22: 674	M	Sep-22	380	⇧	●			High is good
Quality & Safety	Serious Incidents	0	M	Sep-22	25	⇧				Low is good
	Infection Control - C-Difficile	12	M	Sep-22	22	⇩	●	4 / 6	12.35	Low is good
	Infection Control - MRSA	0	M	Sep-22	2	⇧	●	5 / 6	0.64	Low is good

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

Adjustments to the national Mental Health Services and IAPT datasets to support reporting under the new commissioning structures are underway but are yet to be included. As a result ICB level breakdowns have not been included in the July or August 2022 data and current ICB reporting is to June 2022. The issue is expected to be rectified in the September 2022 data due to be published in December.

A number of providers of CYP Eating Disorders data have been affected by a recent cyber incident. National, regional system-level data has been removed from the Q2 publication as they are known to not be a true reflection of activity at this point in time. Efforts to resolve provider data submission issues are on-going.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

APPENDIX A

Report to the Quality and Performance Committee
Quality and Safety of Mental Health, Learning Disability and Autism Inpatient Services
Date of Meeting: 02 December 2022

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

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

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

Report Authors	Diana Butterworth – Head of Quality and Strategic Lead for Mental Health Naomi Elvin – Quality Manager for Mental Health Services
Date to which the information this report is based on was accurate	November 2022

Senior Responsible Owner	Maria Laffan – Deputy Chief Nurse

Executive summary

Further to the BBC Panorama and Dispatches' programmes which evidenced the abuse of patients whilst in the care of an NHS Trust facility, a letter from Claire Murdoch (NHSE National Director of Mental Health) was received to ensure that collectively we do all in our power to identify, eradicate and prevent this abuse from happening. (Appendix A)

What are the available options?

- As an immediate response, assurance was sought from ELFT and CNWL to identify work being undertaken locally and for those individuals placed out of area who were directly commissioned by the Integrated Care Board.

- Enable understanding of the overall quality assurance processes for BLMK residents (adult MH, LD&A or CYP) utilising Inpatient services, whether our main providers (ELFT/CNWL), private providers and those in OOA placements.

- Receive assurances from main MH & LD providers in BLMK on safety assurances including "Use of force act " that provides transparency and accountability in MH units.

- Developing a process of assurance across the system relating to the procuring and ongoing oversight of private hospital provision when BLMK residents are placed outside the usual contractual arrangements with ELFT or CNWL in patient services. This will include the defining of roles and responsibilities for due diligence prior to placement (which would include confirmation and discussion with the host commissioner, service level agreement/quality schedule if not in place).

Recommendation/s

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

1) That this is the first update, this will be an extensive piece of work
2) Further updates to follow

Key Risks and Issues

1. There is a risk that BLMK residents are being mistreated within Mental Health in patient units both in and out of area. A system wide response to map and implement due diligence and oversight processes and ensure that people are safe and have agreed discharge plans in place.

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

681 - Quality and Safety of Mental Health, Learning Disability and Autism Inpatient Services

Are there any financial implications or other resourcing implications?

Further guidance is expected from NHSE/I, however there is an expectation that prioritisation across the BLMK system to ensure the safety of individuals in mental health in patient services. **This has potential to require additional resource if this becomes a large-scale assurance programme.**

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

Click to view Green Plan

How will / does this work help to address inequalities?

Current assurance processes

- Developing work with main MH providers ELFT and CNWL on assurance and leadership in provision of safe inpatient MH and LD services.

- **Learning Disability & Autism Patients:** TCP leads carry out 8 weekly quality oversight visits with people with an LD A in acute MH inpatient settings. NHSE regional colleagues shared Senior Quality Steering Group Terms of Reference and Governance structure in relation to quality oversight process for TCP patients. (Appendix B and C)

- **Children & Young People:** Daily Dashboards from CNWL/ELFT received into the ICB, further work to identify provision used with number of days from admission, due diligence/contractual arrangements, and on-going oversight.

- **Provider Collaborative:** Gaining information in regard to devolved responsibilities of specialist commissioning and oversight of private providers within the BLMK geographical area.

- **ELFT Out of Area:** Information held within the ICB Complex Case Management Team data system, further work to identify provision used with number of days from admission, due diligence/contractual arrangements, and on-going oversight. ELFT/ICB to review processes.

- **CNWL Out of Area:** Contracted to CNWL for procurement, oversight, and monitoring. Current caseload = 22. Due diligence process in place for procurement and oversight/CPA review however in the process of increasing governance/contractual process.

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

Kaysie Conroy (Senior Commissioner for Learning Disability & Autism, BLMK ICB)
Jenny Peckham (Deputy Lead for Learning Disability & Autism, NHSE East of England)
Louise Keran (Complex Care Business Manager Mental Health, Learning Disability & Autism, BLMK ICB)
Tasha Newman (Assistant Director, Central Bedfordshire Mental Health, and Pan Bedfordshire Early Intervention, Rehabilitation and ADHD Services, ELFT)
Bridget Moffat (Senior Commissioning Manager for Children & Young People, BLMK ICB)
Nicky McCallum (Out of County Placements Manager Rehab and Recovery Team, CNWL)
Simon Hardcastle (Associate Director, Quality & Nursing Directorate, BLMK ICB)
Rachel Volpe (Head of Mental Health & Learning Disability Transformation, BLMK ICB)
Claire McKenna (Director of Nursing MH ELFT)
James Smith (Director of Nursing Diggory CNWL)
Maria Laffan (Deputy Chief Nurse BLMK ICB)

Next steps:

To map the processes for each element and agree roles and responsibilities to ensure that all BLMK residents have quality assurance and discharge plans in place for both in and out of area provision.

Appendices.

- **A – National director (Clare Murdoch) MH letter – regarding assurances for inpatient MH provision**
- **B- Template for Transforming KLOE data collection on safe services and patient experiences**
- **C- Terms of Reference for Safe& wellbeing reviews (group to set strategic direction and support to seek resolution of escalated risks and issues for identified inpatient units and for individuals with a learning disability and autism, both in the community and in inpatient care) Approach to be used for approach for MH inpatient units**
- **D- ELFT – assurance document on strategy for safer inpatient wards**

Appendix A — Quality and Safety of Inpatient Services

Appendix B — #BLMK TCP OSV & LoS Template (v2.0).xl

Appendix C — Senior Quality Steering Group ToR v

Appendix D — ELFT Governance Strategy - Prov Safe

APPENDIX B

Update 26 October 2022

BLMK ICS System Oversight Framework - October 2022

Domain	Area	Aggregation Score	Indicator	Value	Rank
Leadership and capability	Leadership	ICB	S60a Aggregate score for NHS staff survey questions that measure perception of leadership culture	6.75/10	35/42
People	Belonging in the NHS	ICB	S072a Proportion of staff who agree that their organisation acts fairly with regard to career progression /promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	55.3%	25/42
People	Growing for the future	ICB	S074a FTE doctors in General Practice per 10,000 weighted patients	5.13/10,000	35/42
People	Growing for the future	ICB	S075a Direct patient care staff in GP practices and PCN's per 10,000 weighted patients	5.1/10,000	23/42
People	Looking after our people	ICB	S63a Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	10.7%	15/42
People	Looking after our people	ICB	S63b Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	18.8%	19/42
People	Looking after our people	ICB	S63c Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	29.2%	35/42
People	Looking after our people	ICB	S067a Leaver rate	18.5%	35/41
People	Looking after our people	ICB	S068a Sickness absence rate	4.32%	8/42
People	Looking after our people	ICB	S069a Staff survey engagement theme score	5.53%	25/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	Sub ICB	S053a Proportion of people with CVD treated for cardiac high risk conditions	91.9%	4/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	Sub ICB	S053b % of hypertension patients who are treated to target as per NICE guidelines	57.0%	37/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	Sub ICB	S053c % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	56.7%	18/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	Sub ICB	S055a Number of referrals to NHS digital weight management services per 100k head of population	8.7/100,000	41/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	ICB	S115a Proportion of diabetes patients that have received all eight diabetes care processes	46.80%	22/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	ICB	S116a Proportion of adult acute inpatient settings offering smoking cessation services	0%	14/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	ICB	S116b Proportion of maternity inpatient settings offering smoking cessation services	0%	10/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	Provider	S117a Proportion of patients who have a first consultation in a post covid service within six weeks of referral	13%	16/25
Preventing ill health and reducing inequalities	Screening, vaccination and immunisation	Sub ICB	S046a: Population vaccination coverage – MMR for two doses (5 years olds)	87%	29/42
Preventing ill health and reducing inequalities	Screening, vaccination and immunisation	Sub ICB	S047a Proportion of people over 65 receiving a seasonal flu vaccination	82.1%	33/42
Preventing ill health and reducing inequalities	Screening, vaccination and immunisation	Sub ICB	S050a Cancer – cervical screening coverage: % females aged 25-64 attending screening within the target period	69.3%	34/42
Quality of care, access and outcomes	Cancer	ICB	S010a Cancer - Total patients treated for cancer compared with the same point in 2019/20	105.00%	15/42
Quality of care, access and outcomes	Cancer	Provider	S011a Cancer - Percentage of patients on the waiting list who have been waiting more than 62 days	11.10%	22/42
Quality of care, access and outcomes	Cancer	ICB	S012a Cancer – Proportion of patients meeting the faster cancer diagnosis standard	71.40%	17/42
Quality of care, access and outcomes	Elective Care	ICB	S007a Total elective activity undertaken compared with 2019/20 baseline	96.4%	22/42
Quality of care, access and outcomes	Elective Care	ICB	S007b Elective Activity: Completed pathway elective activity growth	94.4%	26/42
Quality of care, access and outcomes	Elective Care	Provider	S009a RTT Waiting lists - Total patients waiting more than 52 weeks to start consultant led treatment	6,135	18/42
Quality of care, access and outcomes	Elective Care	Sub ICB	S009a RTT Waiting lists - Total patients waiting more than 52 weeks to start consultant led treatment	7,035	23/42
Quality of care, access and outcomes	Elective Care	Provider	S009b RTT Waiting lists - Total patients waiting more than 78 weeks to start consultant led treatment	405	12/42
Quality of care, access and outcomes	Elective Care	Sub ICB	S009b RTT Waiting lists - Total patients waiting more than 78 weeks to start consultant led treatment	510	11/42
Quality of care, access and outcomes	Elective Care	Provider	S009c RTT Waiting lists - Total patients waiting more than 104 weeks to start consultant led treatment	1	5/42
Quality of care, access and outcomes	Elective Care	Sub ICB	S009c RTT Waiting lists - Total patients waiting more than 104 weeks to start consultant led treatment	4	5/42
Quality of care, access and outcomes	Elective Care	Provider	S013a Diagnostic Activity Levels: Imaging	90.9%	36/42
Quality of care, access and outcomes	Elective Care	Sub ICB	S013a Diagnostic Activity Levels: Imaging	90.7%	36/42
Quality of care, access and outcomes	Elective Care	Provider	S013b Diagnostic activity levels: Physiological measurement	213.2%	1/42
Quality of care, access and outcomes	Elective Care	Sub ICB	S013b Diagnostic activity levels: Physiological measurement	175.8%	2/42
Quality of care, access and outcomes	Elective Care	Provider	S013c Diagnostic Activity Levels - Endoscopy	81.7%	27/42
Quality of care, access and outcomes	Elective Care	Sub ICB	S013c Diagnostic Activity Levels - Endoscopy	79.8%	25/42
Quality of care, access and outcomes	Elective Care	Provider	S013d Diagnostic Activity Levels - Total	93.4%	32/42
Quality of care, access and outcomes	Elective Care	Sub ICB	S013d Diagnostic Activity Levels - Total	92.8%	34/42
Quality of care, access and outcomes	Maternity and children's health	ICB	S022a Maternity – number of stillbirths per 1,000 total births	3.62/1,000	31/42
Quality of care, access and outcomes	Maternity and children's health	ICB	S104a Neonatal deaths per 1,000 total live births	1.27/1,000	13/42
Quality of care, access and outcomes	Mental health service	ICB	S081a Access rate for IAPT Services	88.6%	6/42
Quality of care, access and outcomes	Mental health service	ICB	S084a Number of children and young people accessing mental health services as a % of population	115.6%	6/42
Quality of care, access and outcomes	Mental health service	ICB	S085a Proportion of people with severe mental health illness receiving a full annual physical health check and follow up interventions	80.9%	12/42
Quality of care, access and outcomes	Mental health service	ICB	S086a Inappropriate adult acute mental health placement out of area placement bed days	595	12/42
Quality of care, access and outcomes	Mental health service	ICB	S110a Access rates to community mental health services for adult and older adults with severe mental illness	97.3%	13/42
Quality of care, access and outcomes	Outpatient transformation	ICB	S101a Outpatient follow up activity levels compared with 2019/20 baseline	97.9%	27/42
Quality of care, access and outcomes	Personalised care	ICB	S031a Rate of personalised care interventions	39.7/1,000	39/42
Quality of care, access and outcomes	Personalised care	ICB	S032a Personal Health Budgets	1.16/1,000	32/42
Quality of care, access and outcomes	Primary care and community services	ICB	S001a Number of general practice appointments per 10,000 weighted patients	4288.71/10,000	25/42
Quality of care, access and outcomes	Primary care and community services	ICB	S106a Available virtual ward capacity per 100k head of population	0/100,000	41/42
Quality of care, access and outcomes	Primary care and community services	ICB	S107a Percentage of 2-hour Community Response referrals where care was provided within two hours	95.5%	5/41
Quality of care, access and outcomes	Primary care and community services	ICB	S108a Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from a general practice	32.8/100,000	18/42
Quality of care, access and outcomes	Primary care and community services	ICB	S108b Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from NHS111 per 100,000 population	74.2/100,000	14/42
Quality of care, access and outcomes	Primary care and community services	ICB	S109a Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	74.1%	14/42
Quality of care, access and outcomes	Safe, high quality care	ICB	S037a Percentage of patients describing their overall experience of making a GP appointment as good	45.9%	42/42
Quality of care, access and outcomes	Safe, high quality care	Provider	S040a Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	6	23/42
Quality of care, access and outcomes	Safe, high quality care	Provider	S041a Clostridium difficile infection rate	136.1%	37/42
Quality of care, access and outcomes	Safe, high quality care	Sub ICB	S041a Clostridium difficile infection rate	117.4%	36/42
Quality of care, access and outcomes	Safe, high quality care	Provider	S042a E Coli Blood stream infection rate	151.1%	42/42
Quality of care, access and outcomes	Safe, high quality care	Sub ICB	S042a E Coli Blood stream infection rate	118.0%	41/42
Quality of care, access and outcomes	Safe, high quality care	Sub ICB	S044a Antimicrobial resistance: appropriate prescribing of antibiotics and broad spectrum antibiotics in primary care	93.4%	28/42
Quality of care, access and outcomes	Safe, high quality care	Sub ICB	S044b Antimicrobial resistance: appropriate prescribing of antibiotics and broad spectrum antibiotics in primary care	8.84%	23/42
Quality of care, access and outcomes	Safe, high quality care	ICB	S121a NHS Staff Survey compassionate culture people promise element sub-score	7.2/10	12/42
Quality of care, access and outcomes	Safe, high quality care	ICB	S121b NHS Staff Survey raising concerns people promise element sub-score	6.5/10	21/42

KEY for Quartile Range

	Highest performing quartile
	Interquartile range
	Lowest performing quartile

Link to NHS System Oversight Framework Dashboard 2022/23

System Oversight Framework Dashboard - NHS System Oversight and Assessment - FutureNHS Collaboration Platform

APPENDIX B

Updated 26 October 2022

BLMK ICS System Oversight Framework - October 2022

Theme	Aggregation Source	Indicator	Period	Value	National Value	Target	Change from previous period	Quartile range
GP	ICB	S001a Number of general practice appointments per 10,000 weighted patients	08 2022	4288.71/10,000	4305.54/20,000		Deterioration	25/42
Elective Care	ICB	S007a Total elective activity undertaken compared with 2019/20 baseline	07 2022	96.4%		104%	Deterioration	22/42
	ICB	S007b Elective Activity: Completed pathway elective activity growth	08 2022	94.4%		110%	Improvement	26/42
Waiting Lists	Provider	S009a RTT Waiting lists - Total patients waiting more than 52 weeks to start consultant led treatment	08 2022	6,135	368,072		Deterioration	18/42
	Sub ICB	S009a RTT Waiting lists - Total patients waiting more than 52 weeks to start consultant led treatment	08 2022	7,035	353,669		Deterioration	23/42
	Provider	S009b RTT Waiting lists - Total patients waiting more than 78 weeks to start consultant led treatment	08 2022	405	48,546		Deterioration	12/42
	Sub ICB	S009b RTT Waiting lists - Total patients waiting more than 78 weeks to start consultant led treatment	08 2022	510	46,410		Deterioration	11/42
	Provider	S009c RTT Waiting lists - Total patients waiting more than 104 weeks to start consultant led treatment	08 2022	1	2,343	0	Deterioration	5/42
	Sub ICB	S009c RTT Waiting lists - Total patients waiting more than 104 weeks to start consultant led treatment	08 2022	4	2,396	0	Improvement	5/42
Cancer	ICB	S010a Cancer - Total patients treated for cancer compared with the same point in 2019/20	08 2022	105.0%		100%	Deteriorating	15/42
	Provider	S011a Cancer - Percentage of patients on the waiting list who have been waiting more than 62 days	w/e 16/10/22	11.6%			Deterioration	22/42
	ICB	S012a Cancer – Proportion of patients meeting the faster cancer diagnosis standard	08 2022	71.4%	69.5%	75%	Improvement	17/42
	Provider	S013a Diagnostic Activity Levels: Imaging	08 2022	90.9%	99.2%	120%	Deterioration	36/42
	Sub ICB	S013a Diagnostic Activity Levels: Imaging	08 2022	90.7%	97.1%	120%	Deterioration	36/42
	Provider	S013b Diagnostic activity levels: Physiological measurement	08 2022	213.2%	93.4%	120%	Deterioration	1/42
	Sub ICB	S013b Diagnostic activity levels: Physiological measurement	08 2022	175.8%	91.5%	120%	Deterioration	2/42
	Provider	S013c Diagnostic Activity Levels - Endoscopy	08 2022	81.7%	86.9%	120%	Improvement	27/42
	Sub ICB	S013c Diagnostic Activity Levels - Endoscopy	08 2022	79.8%	84.4%	120%	Improvement	25/42
	Provider	S013d Diagnostic Activity Levels - Total	08 2022	93.4%	97.8%	120%	Deterioration	32/42
	Sub ICB	S013d Diagnostic Activity Levels - Total	08 2022	92.8%	95.7%	120%	Deterioration	34/42
Maternity	ICB	S022a Stillbirths per 1,000 total births	2020	3.2/1,000	3.29/1,000		Deterioration	31/42
Personalised Care	ICB	S031a Rate of personalised care interventions	22-23 Q1	39.7/1,000	60.74/1,000		Improvement	39/42
	ICB	S032a Personal Health Budgets	21-22 Q4	1.16/1,000	2.03/1,000		Improvement	32/42
	ICB	S037a Percentage of patients describing their overall experience of making a GP appointment as good	2022	45.9%	56.2%		Deterioration	42/42
Infection Control	Provider	S040a Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	08 2022	6	257	0	Deterioration	23/42
	Sub ICB	S040a Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	08 2022	19	719	0	Improvement	27/42
	Provider	S041a Clostridium difficile infection rate	08 2022	136.1%	112.7%	100%	Deterioration	37/42
	Sub ICB	S041a Clostridium difficile infection rate	08 2022	117.4.8%	108%	100%	Deterioration	36/42
	Provider	S042a E Coli Blood stream infection rate	08 2022	151.1%	108.1%	100%	Deterioration	42/42
	Sub ICB	S042a E Coli Blood stream infection rate	08 2022	118%	105.7%	100%	Deterioration	41/42
	Sub ICB	S044a Antimicrobial resistance: appropriate prescribing of antibiotics and broad spectrum antibiotics in primary care	08/21 - 07/22	93.4%	88.5%	<87.1%	Deterioration	28/42
	Sub ICB	S044b Antimicrobial resistance: appropriate prescribing of antibiotics and broad spectrum antibiotics in primary care	08/21 - 07/22	8.84%	8.41%	<10%	Improvement	23/42
Vaccination	Sub ICB	S046a Population vaccination coverage – MMR for two doses (5 years olds)	21-22 Q4	87.0%	85.9%	>95%	Improvement	29/42
	Sub ICB	S047a Proportion of people over 65 receiving a seasonal flu vaccination	02 022	82.1%	82.3%	85%	Improvement	33/42
Prevention and long term conditions	Sub ICB	S050a Cancer – cervical screening coverage: % females aged 25-64 attending screening within the target period	21-22 Q4	69.3%	70.8%	75%	Improvement	34/42
	Sub ICB	S053a Proportion of people with CVD treated for cardiac high risk conditions	2021-2022	91.9%	89.0%	90%		4/42
	Sub ICB	S053b % of hypertension patients who are treated to target as per NICE guidelines	2021-2022	57%	60.4%	80%	Improvement	37/42
	Sub ICB	S053c % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	03 2022	56.7%	56.9%	45%		18/42
	Sub ICB	S055a Number of referrals to NHS digital weight management services per 100k head of population	22-23 Q1	8.7/100,000	56.2/100,000		Deterioration	41/42
Workforce	ICB	S60a Aggregate score for NHS staff survey questions that measure perception of leadership culture	2021	6.75/10				35/42
	ICB	S63a Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	2021	10.7%			Deterioration	15/42
	ICB	S63b Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	2021	18.8%			Deterioration	19/42
	ICB	S63c Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	2021	29.2%			Improvement	35/42
	ICB	S067a Leaver rate	07 2022	18.5%	16.0%		Improvement	35/41
	ICB	S068a Sickness absence rate	05 2022	4.32%	5.03%		Improvement	8/42
	ICB	S069a Staff survey engagement theme score	2021	5.53/10			Improvement	25/42
	ICB	S072a Proportion of staff who agree that their organisation acts fairly with regard to career progression/proportion regardless of ethnic background, gender, religion, sexual orientation, disability or age.	2021	55.3%			Improvement	25/42
	ICB	S074a FTE doctors in General Practice per 10,000 weighted patients	07 2022	5.13/10,000	5.59/10,000		Improvement	35/42
	ICB	S075a Direct patient care staff in GP practices and PCNs per 10,000 weighted patients	22-23 Q1	5.1/10,000	4.98/10,000			23/42
Mental Health	ICB	S081a Access rate for IAPT Services	22-23 Q1	88.6%		100%	Deterioration	6/42
	ICB	S084a Number of children and young people accessing mental health services as a % of population	06 2022	115.6%		100%	Deterioration	6/42
	ICB	S085a Proportion of people with severe mental health illness receiving a full annual physical health check and follow up interventions	06 2022	80.9%	73.2%	100.0%	Improvement	12/42
	ICB	S086a Inappropriate adult acute mental health placement out of area placement bed days	05/22 - 07/22	595		0	Improvement	12/42
Quality of Care, access and outcomes	ICB	S101a Outpatient follow up activity levels compared with 2019/20 baseline	07 2022	97.9%		75%	Improvement	27/42
	ICB	S104a Neonatal deaths per 1,000 total live births	2020	1.27/1,000	1.5/1,000		Improvement	13/42
	ICB	S106a Available virtual ward capacity per 100k head of population	09 2022	0/100,000	12.2/100,000	40/100,000		41/42
	ICB	S107a Percentage of 2-hour Community Response referrals where care was provided within two hours	07 2022	95.5%		70%	Deterioration	5/41
	ICB	S108a Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from a general practice	03 2022	32.8/100,000			Improvement	18/42
	ICB	S108b Number of Completed Referrals to Community Pharmacist Consultation Serivce (CPCS) from NHS111 per 100,000 population	03 2022	74.2/100,000			Improvement	14/42
	ICB	S109a Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	09 2022	74.1%	70.2%	100%	Deterioration	14/42
	ICB	S110a Access rates to community mental health services for adult and older adults with severe mental illness	06 2022	97.3%		100%	Deterioration	13/42
	ICB	S115a Proportion of diabetes patients that have received all eight diabetes care processes	21-22 Q4	46.8%	46.7%		Improvement	22/42
	ICB	S116a Proportion of adult acute inpatient settings offering smoking cessation services	07 2022	0.0%	9.87%	100%		14/42
	ICB	S116b Proportion of maternity inpatient settings offering smoking cessation services	07 2022	0.0%	10.70%	100%		10/42
	Provider	S117a Proportion of patients who have a first consultation in a post covid service within six weeks of referral	07 2022	13.0%	34.2%		Improvement	16/25
	ICB	S121a NHS Staff Survey compassionate culture people promise element sub-score	2021	7.2/10				12/42
	ICB	S121b NHS Staff Survey raising concerns people promise element sub-score	2021	6.5/10				21/42

KEY for Quartile Range

	Highest performing quartile
	Interquartile range
	Lowest performing quartile

Link to NHS System Oversight Framework Dashboard 2022/23

System Oversight Framework Dashboard - NHS System Oversight and Assessment - FutureNHS Collaborati

APPENDIX B

Updated 26 October 2022

BEDFORDSHIRE HOSPITALS TRUST System Oversight Framework - October 2022

Theme	Indicator	Period	Value	National Value	Target	Change from previous period	Quartile range
Elective Care	S007a Total elective activity undertaken compared with 2019/20 baseline	07 2022	94.4%		104%	Deterioration	89/137
	S007b Elective Activity: Completed pathway elective activity growth	08 2022	79.9%		110%	Improvement	118/137
Waiting Lists	S009a RTT Waiting lists - Total patients waiting more than 52 weeks to start consultant led treatment	08 2022	3,935	368,072		Deterioration	110/137
	S009b RTT Waiting lists - Total patients waiting more than 78 weeks to start consultant led treatment	08 2022	353	48,546		Deterioration	102/137
	S009c RTT Waiting lists - Total patients waiting more than 104 weeks to start consultant led treatment	08 2022	0	2,343	0		1/137
	S011a Cancer - percentage of patients on the waiting list who have been waiting more than 62 days	w/e 16/10/22	10.9%	0		Deterioration	75/134
	S012a Cancer – Proportion of patients meeting the faster cancer diagnosis standard	08 2022	70.4%	70	75%	Improvement	73/137
Diagnostics	S013a Diagnostic Activity Levels: Imaging	08 2022	84.8%	99.2%	120%	Deterioration	123/137
	S013b Diagnostic activity levels: Physiological measurement	08 2022	219.3%	93.4%	120%	Deterioration	3/137
	S013c Diagnostic Activity Levels - Endoscopy	08 2022	90.3%	86.9%	120%	Improvement	58/137
	S013d Diagnostic Activity Levels - Total	08 2022	88.2%	97.8%	120%	Deterioration	118/137
Maternity	S022a Maternity – stillbirths per 1,000 total births	2020	3.69/1,000	3.29/1,000		Deterioration	84/119
Mortality	S034a Summary Hospital level Mortality Indicator	05 2022	2 - as expected				15/121
CQC	S035a Overall CQC rating	09 2022	3 - Good				14/136
Patient Safety	S038a Consistency of reporting patient safety incidents	02/22 - 07/22	100%		100%		1/137
	S039a National Patient Safety Alerts not declared complete by deadline	04 2022	1		0		100/137
Infection Control	S040a Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	08 2022	2	257	0		81/137
	S401a Clostridium difficile infection rate	07 2022	124.1%	110.7%	100%	Deterioration	97/137
	S041a Clostridium difficile infection rate	08 2022	124.1%	112.7%	100%		90/137
	S042a E Coli Blood stream infection rate	08 2022	139.1%	108.1%	100%	Deterioration	123/137
Leadership	S059a CQC well-led rating	09 2022	3 - Good				17/136
Staff	S60a Aggregate score for NHS staff survey questions that measure perception of leadership culture	2021	6.63/10				107/137
	S63c Proportion of staff who say they have personally experienced harrassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	2021	28.6%			Deterioration	95/137
Workforce	S067a Leaver rate	07 2022	18.4%	16.0%		Improvement	70/137
	S068a Sickness absence rate	05 2022	4.25%	5.03%		Improvement	34/137
	S069a Staff Survey engagement theme score	2021	6.85/10			Deterioration	73/137
	S071b Proportion of staff in senior leadership roles who are women	08 2022	52.4%		62%	Deterioration	120/136
	S072a Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	2021	53.6%			Improvement	97/137
Quality of Care, access and outcomes	S104a Neonatal deaths per 1,000 total live births	2020	1.79/1,000	1.5/1,000%		Improvement	86/115
	S105a Proportion of patients discharged from hospital to their usual place of residence	08 2022	96%	93%		Improvement	21/137
	S121a NHS Staff Survey compassionate culture people promise element sub-score	2021	7.1/10				68/137
	S121b NHS Staff Survey raising concerns people promise element sub-score	2021	6.3/10				95/137

KEY for Quartile Range

	Highest performing quartile
	Interquartile range
	Lowest performing quartile

Link to NHS System Oversight Framework Dashboard 2022/23

System Oversight Framework Dashboard - NHS System Oversight and Assessment - FutureNHS Collaboratior

APPENDIX B

Udated 26 October 2022

MILTON KEYNES TRUST System Oversight Framework - October 2022

Theme	Indicator	Period	Value	National Value	Target	Change from previous period	Quartile range
Elective Care	S007a Total elective activity undertaken compared with 2019/20 baseline	07 2022	101.7%		104%	Deterioration	46/137
	S007b Elective Activity: Completed pathway elective activity growth	08 2022	135.1%		110%	Improvement	4/137
Waiting Lists	S009a RTT Waiting lists - Total patients waiting more than 52 weeks to start consultant led treatment	08 2022	2,200	368,072		Deterioration	93/137
	S009b RTT Waiting lists - Total patients waiting more than 78 weeks to start consultant led treatment	08 2022	52	48,546		Deterioration	52/137
	S009c RTT Waiting lists - Total patients waiting more than 104 weeks to start consultant led treatment	08 2022	1	2,343	0	Deterioration	65/137
Cancer	S010a Cancer - Total patients treated for cancer compared with the same point in 2019/20	07 2022	124.9%		100%	Improvement	17/133
	S011a Cancer - percentage of patients on the waiting list who have been waiting more than 62 days	w/e 16/10/22	11.4%	11.6%		Deterioration	78/134
	S012a Cancer – Proportion of patients meeting the faster cancer diagnosis standard	08 2022	73.4%	1	75%	Deterioration	55/137
Diagnostics	S013a Diagnostic Activity Levels: Imaging	08 2022	115.3%	99.2%	120%	Improvement	21/137
	S013b Diagnostic activity levels: Physiological measurement	08 2022	200.9%	93.4%	120%	Improvement	4/137
	S013c Diagnostic Activity Levels - Endoscopy	08 2022	30.6%	86.9%	120%	Deterioration	121/137
	S013d Diagnostic Activity Levels - Total	08 2022	114.6%	97.8%	120%	Improvement	16/137
Maternity	S022a Maternity – stillbirths per 1,000 total births	2020	3.36/1,000	3.29/1,000		Deterioration	64/119
Mortality	S034a Summary Hospital level Mortality Indicator	05 2022	2				15/121
CQC	S035a Overall CQC rating	09 2022	3 - Good				14/136
Patient Safety	S038a Consistency of reporting patient safety incidents	02/22 - 07/22	100%		100%		1/137
	S039a National Patient Safety Alerts not declared complete by deadline	04 2022	3		0		124/137
Infection Control	S040a Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	08 2022	4	257	0		111/137
	S401a Clostridium difficile infection rate	07 2022	185.7%	110.7%	100%	Improvement	134/137
	S041a Clostridium difficile infection rate	08 2022	185.7%	112.7%	100%		134/137
	S042a E Coli Blood stream infection rate	08 2022	178.6%	108.1%	100%	Deterioration	133/137
Leadership	S059a CQC well-led rating	09 2022	3 - Good				17/136
	S060a Aggregate score for NHS staff survey questions that measure perception of leadership culture	2021	6.98/10				28/137
	S063a Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	2021	9.96%			Deterioration	27/110
	S63b Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	2021	19.5%			Deterioration	50/107
	S063c Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	2021	29.6%			Deterioration	110/137
Workforce	S067a Leaver rate	07 2022	20.3%	16.0%		Improvement	110/137
	S068a Sickness absence rate	05 2022	4.57%	5.03%		Improvement	55/137
	S069a Staff Survey engagement theme score	2021	7.21/10			Deterioration	16/137
	S071b Proportion of staff in senior leadership roles who are women	08 2022	61.5%		62%	Deterioration	66/136
	S072a Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	2021	55.0%			Deterioration	79/137
Quality of Care, access and outcomes	S104a Neonatal deaths per 1,000 total live births	2020	0.28/1,000	1.5/1,000		No data	2/115
	S105a Proportion of patients discharged from hospital to their usual place of residence	08 2022	93.80%	93%		Deterioration	53/137
	S117a Proportion of patients who have a first consultation in a post covid service within six weeks of referral	07 2022	13.0%	34.2%		Improvement	29/61
	S121a NHS Staff Survey compassionate culture people promise element sub-score	2021	7.4/10				30/137
	S121b NHS Staff Survey raising concerns people promise element sub-score	2021	6.8/10				24/137

KEY for Quartile Range

	Highest performing quartile
	Interquartile range
	Lowest performing quartile

Link to NHS System Oversight Framework Dashboard 2022/23

System Oversight Framework Dashboard - NHS System Oversight and Assessment - FutureNHS Collaborati

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
16. Finance Report September 2022 (Month 6)

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

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

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

Report Author	Finance Department
Date to which the information this report is based on was accurate	28/10/2022
Senior Responsible Owner	Dean Westcott, Chief Finance Officer

Executive summary

This paper sets out the 2022/23 BLMK ICS financial position at month 6 (September 2022) for revenue and capital spend.

NHS organisations hosted within the system are reporting a £0.1m adverse Income & Expenditure variance to plan at Month 6; the forecast remains delivery of a breakeven position.

System efficiency plans are on target year-to-date and forecast to deliver the in full by the end of the year.

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

What are the available options?

Not applicable

Recommendation/s

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

1) the month 6 and forecast position for revenue and capital
2) the risks to the financial forecast

Key Risks and Issues

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

- The delivery of efficiency and productivity plans.
- Inflationary pressures over funding levels.
- The impact of the pay settlement for NHS staff not being fully funded.
- Elective Services Recovery Funding: the system plan is underpinned by full receipt of Elective Recovery Fund (ERF) income. Quarters 1 & 2 has proved challenging for providers. Funding has been confirmed for the first six months of the financial year but the arrangements in the second half of the year remain uncertain.

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

Are there any financial implications or other resourcing implications?

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

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

Click to view Green Plan

How will / does this work help to address inequalities?
The finance plan reflects operational plans that include a focus on addressing inequalities.
The following individuals were consulted and involved in the development of this report:
BLMK Directors of Finance
Next steps:
Appendices

1.0 Introduction

1.1 The purpose of this paper is to report the Integrated Care System (ICS) financial position at month 6 (September) for those NHS organisations that form part of the Bedfordshire, Luton and Milton Keynes (BLMK) ICS financial control total. These organisations are:

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

A commentary on the current financial position of Local Authority partners is included in Appendix A.

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

2.0 System Income & Expenditure Position

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

Surplus / (Deficit)	Year-to-date				Forecast Outturn			
	Plan	Actual	Variance		Plan	FOT	Variance	
	£m	£m	£m	%	£m	£m	£m	%
Bedfordshire Hospital NHS FT	0.0	0.3	0.3	0.0%	0.0	0.0	0.0	0.0%
Milton Keynes NHS FT	(3.7)	(4.1)	(0.4)	10.8%	0.0	0.0	0.0	0.0%
BLMK CCG/ICB	0.0	0.0	0.0	0.0%	0.0	0.0	0.0	0.0%
Intra ICS Organisations	**(3.7)**	**(3.8)**	**(0.1)**	**0.0%**	**0.0**	**0.0**	**0.0**	**0.0%**

2.2 The ICS is reporting a year-to-date deficit to plan of £0.1m and forecasting breakeven by the end of the year.

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

Bedfordshire Hospital NHS Foundation Trust

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

Income & Expenditure	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income	350,388	359,140	8,752	700,757	713,836	13,079
Pay	(226,206)	(232,068)	(5,862)	(452,338)	(466,338)	(14,000)
Non-Pay	(124,195)	(126,760)	(2,565)	(248,419)	(247,498)	921
SURPLUS / (DEFICIT)	**(13)**	**311**	**324**	**0**	**0**	**0**

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

- Income – Income ahead of plan due to the pay awards. Forecast has been updated to reflect this.
- Pay – Higher levels of bank and agency, particularly on medical staffing, driven by high levels of emergency activity, staff sickness due to covid and elective recovery. In month the swing is caused by the pay award arrears.
- Non-Pay – High levels of drugs spend.

Milton Keynes University NHS Foundation Trust

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

Income & Expenditure	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income	162,224	165,879	3,655	326,996	331,064	4,068
Pay	(105,958)	(110,543)	(4,585)	(208,207)	(212,275)	(4,068)
Non-Pay	(60,007)	(59,436)	571	(118,789)	(118,789)	0
SURPLUS / (DEFICIT)	**(3,741)**	**(4,100)**	**(359)**	**0**	**0**	**(0)**

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

- Income – additional income re: wage award
- Pay – wage award backpay and higher than expected temporary staffing costs
- Non-Pay – lower than expected inflationary pressures during the first half of the year

Integrated Care Board

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

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

The table below shows ICB performance against key financial performance indicators. At month 6 the ICB is delivering and forecasting full achievement of these metrics.

Performance Measure	Year To Date - Month 6			Forecast		
	Target	Actual	Variance	Target	Actual	Variance
Revenue Resource Limit	£876.4m	£876.4m	£0.0m	£1,797.4m	£1,797.4m	£0.0m
Capital Resource Limit	£0.0m	£0.0m	£0.0m	£1.7m	£1.7m	£0.0m
MHIS Expenditure	£76.7m	£78.5m	£1.8m	£153.5m	£154.4m	£0.9m
Efficiency Savings	£7.2m	£7.4m	£0.2m	£15.4m	£15.6m	£0.2m
BPPC	>95%	95%	0%	>95%	95%	0%

The ICB is reporting a breakeven YTD against a planned breakeven position and is forecasting a breakeven financial position. The position by commissioning programme as at month 6 is set out in the table below:

PROGRAMME AREA	YEAR TO DATE - MONTH 06				FORECAST OUTTURN			
	Budget	Actual	Variance		Budget	Forecast	Variance	
	£000	£000	£000	%	£000	£000	£000	%
Acute Services	256,108	253,048	3,060	1.2%	743,947	741,299	2,647	0.4%
Mental Health Services	48,590	48,220	370	0.8%	144,914	144,809	105	0.1%
Better Care Fund	7,729	7,753	(24)	(0.3%)	23,133	23,203	(71)	(0.3%)
Other Community Services	38,759	38,215	544	1.4%	110,113	110,623	(510)	(0.5%)
Continuing Care Services	18,832	19,158	(326)	(1.7%)	55,855	56,979	(1,124)	(2.0%)
Primary Care Co-Commissioning	39,746	39,372	374	0.9%	122,213	123,941	(1,728)	(1.4%)
Prescribing	34,371	36,261	(1,890)	(5.5%)	104,092	106,659	(2,567)	(2.5%)
Other Primary Care Services	8,556	8,004	552	6.5%	23,662	23,306	357	1.5%
Other Programme Services (incl. Reserves)	(7,248)	4,849	(12,097)	166.9%	26,917	35,294	(8,377)	(31.1%)
Total Commissioning Budget	**445,442**	**454,878**	**(9,436)**	**(2.1%)**	**1,354,845**	**1,366,113**	**(11,268)**	**(0.8%)**
Running Costs	**4,292**	**4,150**	**142**	**3.3%**	**14,175**	**13,915**	**260**	**1.8%**
Surplus / (Deficit)	**9,294**	**0**	**9,294**	**100.0%**	**9,294**	**0**	**9,294**	**100.0%**
Total ICB Net Expenditure	**459,028**	**459,028**	**0**	**0.0%**	**1,378,314**	**1,380,028**	**(1,714)**	**(0.1%)**
Expected Allocation from NHSE for ARRs roles	0	0	0	0.0%	1,714	0	1,714	100.0%
Total Net Expenditure after NHSE Allocation	**459,028**	**459,028**	**0**	**0.0%**	**1,380,028**	**1,380,028**	**(0)**	**(0.0%)**

The key variances from budget are highlighted below:

Acute is showing an underspend of £3.1m with a year-end forecast of £2.6m under plan.

The financial position for NHS contracts is a year-to-date underspend of £3.5m and a forecast underspend of £3.3m. The main driver of this underspend in the year-to-date and forecast is Elective Recovery Funding where funding was not received until Q2, this is offset by £3m overspend in the legacy CCG where expenditure was accounted for by the CCG in Q1 where there was no funding source. After adjusting for this the net underspend across the full financial year is £0.4m year-to-date and £0.3m in the forecast.

Non-contracted activity is overspent year-to-date by £0.5m, due to low volume activity (LVA) and independent sector activity.

Mental Health at Month 6 is an underspend of £0.4m and a forecast of £0.1m underspend. The key contributors towards the underspend relate to a reduction in complex placements, with a reduction in volumes as at Month 6.

These are partly offset by continued pressures in S117 care, although growth has significantly reduced since last year. It should be noted that the challenging level of S117 efficiencies will need to be met to ensure to ensure the position does not deteriorate.

There is continuing collaborative work in Bedfordshire to deliver efficiencies and manage timely reviews in the S117 workstream. The responsibility for spend within Bedfordshire and Luton and the financial risk is currently held by the ICB. In Milton Keynes S117 budgets are devolved to the CNWL. CNWL has seen a continued significant increase in specialist high-cost placements and S117 costs from Milton Keynes.

Expenditure on the main mental health NHS providers, CNWL & ELFT, is agreed by block contract and no variance is expected. Although the S117 pressures being incurred by CNWL should be noted above.

The Mental Health Investment Standard target is set by NHSE to ensure growth in mental health spend is protected. This is closely monitored by NHSE together with the additional development funds targeted for mental health. The current MHIS forecast is £0.9m above target.

Other Community Services is underspent by £0.5m year-to-date with a year-end forecast of £0.5k overspend. The forecast variance primarily reflects the continuation of discharge to assess processes following the end of Hospital Discharge Programme and an increase in costs above 2021/22 activity levels due to earlier discharge from hospital. This includes some specific and significant pressures in respect of Acute Brain Injury (ABI), stroke and step down beds. These pressures are partly offset by underspends in other community service areas.

Continuing Care Services is reporting a £0.4m year-to-date overspend with a year-end forecast of £1.1m.

Adult CHC is reporting a year-to-date overspend of £0.4m, which is an improvement in-month. The variance results from an increase in CHC activity and costs - including the impact of inflationary pressures. Further work is underway to assess the risks to the plan and available mitigations.

Primary Care Co-Commissioning is reporting a year-to-date underspend of £0.4m and is mostly attributed to the underspend in additional roles (Additional Roles Reimbursement Scheme, ARRS).

The forecast is an overspend of £1.7m due to the ARRS workforce that Primary Care Networks (PCN) are planning to recruit the second half of the financial year. PCNs were asked to submit new workforce returns in August 2022 and this has been incorporated in the forecast. The overspend is recoverable from the monies that NHSE hold centrally for ARRS funding.

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

Prescribing reports a year-to-date overspend of £1.9m and a forecast overspend of £2.6m. There has been a significant increase in costs associated with No Cheaper Stocks Available (NCSO drugs), Category M drugs. The forecast overspend has been mitigated slightly by a £0.5m rebate allocation received for Direct Oral Anticoagulants (DOACs) in month 6.

3.0 System Efficiency Plans

3.1 The system financial strategy includes delivery of an efficiency plan of £55.6m (for in-system NHS partners).

3.2 The ICS is reporting savings of £24.9m year to date, £0.2m above plan. The forecast remains to deliver the full plan of £55.6m by the end of the year.

Recurrent / Non Recurrent		Year-to-date				Forecast Outturn			
		Plan	Actual	Variance		Plan	Actual	Variance	
		£'000	£'000	£'000	%	£'000	£'000	£'000	%
ICB	Recurrent	3,688	3,990	302	8%	8,214	8,561	347	4%
	Non Recurrent	3,509	3,400	(109)	-3%	7,227	7,094	(133)	-2%
Subtotal		**7,197**	**7,390**	**193**	3%	**15,441**	**15,655**	**214**	1%
BHFT	Recurrent	11,979	11,979	0	0%	23,951	23,951	0	0%
	Non Recurrent	2,100	2,100	0	0%	4,200	4,200	0	0%
Subtotal		**14,079**	**14,079**	**0**	0%	**28,151**	**28,151**	**0**	0%
MKUHFT	Recurrent	2,825	1,490	(1,335)	-47%	9,049	5,242	(3,807)	-42%
	Non Recurrent	600	1,935	1,335	223%	3,000	6,807	3,807	127%
Subtotal		**3,425**	**3,425**	**0**	0%	**12,049**	**12,049**	**0**	0%
Total Efficiencies		**24,701**	**24,894**	**193**	1%	**55,641**	**55,855**	**214**	0%

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

4.0 System Financial Risks

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

Risk Title	Risk Description	Risk Control	Actions
Delivery of Efficiency Programme	As a result of the efficiency plan not being delivered there is a risk that the ICS will not breakeven at the end of 2022/23	Regular meetings with scheme leads to update on progress and ability to stretch, plus any actions required if deviations from plan identified. Presented to Performance & Delivery Group and to Finance & Investment Committee	Ongoing monitoring and early escalation of any scheme deviating from plan. Continued scanning for further opportunities to add to plan to mitigate any shortfalls
Increase in operational and winter pressures	As a result of an increase in operational pressures and winter pressures, there is a risk that additional costs will be incurred that cannot be met from existing resources, resulting in the	Signed contracts in place for all services. Engagement with local authority partners via s75 / BCFs agreed System capacity to enable appropriate discharge to and from step down beds	All contracts to be agreed and signed for acute, 999 and Out of Hours /111 services Prescribing forecast and profile to be understood to identify level of operational pressure ABI / Stroke and s117

	ICS not breaking even at the end of 2022/23.		budget pressures to be monitored
Elective Recovery Fund (ERF)	As a result of activity below target in H2, there is a risk that ERF will be clawed back after costs have been incurred to deliver activity.		Acute activity to be monitored monthly and impact of ERF modelled
Inflation	As a result of inflation being higher than funded via tariff and allocations, there is a risk that providers will face additional costs that they cannot manage.		Monthly monitoring of spend against budget Review of non-recurrent opportunities within 2022/23 available to mitigate inflation
ICB Management / Running Costs	As a result of the pay award being higher than budgeted, and unfunded, which is a real terms cut in Running Costs, there is a risk of a reduction in ICB staffing and capacity to support establishing the new organisation and ways of working,	Vacancy control process NHSE business case completed for interim staff and consultancy spend	Pay award to be modelled and impact understood on each budget Agree approach to managing individual budget pressures with Executive budget holder
Covid	As a result of a new variant of covid or an increase in infections and hospitalisations, costs may increase whilst the covid allocation that was issued to cover these additional costs, has reduced	Reporting of spend against covid allocation monthly to identify early any pressures on funding	Monitoring of covid expenditure within ICB and across ICS

5.0 System Capital

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

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

5.3 The table below shows the year-to-date and forecast financial performance of intra system providers against CDEL and other capital funding sources. The system annual CDEL is £43.3m and at month 6 providers are forecasting that they will deliver a break-even position against this limit. The ICB does not have a CDEL limit.

Capital Plan - Provider Based	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Charge against capital allocation (CDEL)	19,868	21,606	(1,738)	43,341	43,342	(1)
Other capital funding streams	23,240	16,277	6,962	96,776	99,264	(2,488)
Total	**43,108**	**37,884**	**5,224**	**140,117**	**142,606**	**(2,489)**

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

5.5 The table below shows the year-to-date and forecast position for the intra-ICS NHS organisations across all capital funding streams (CDEL and national sources). There is a currently a £2.5m forecast overspend across the intra-ICS organisations - this reflects a timing issue relating to the allocation of funds for non-CDEL national capital programmes and is expected to be amended in future periods, resulting in a breakeven financial forecast.

Intra-ICS Capital Plan	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Bedfordshire Hospital NHS FT	37.1	30.5	6.5	116.7	117.6	(1.0)
Milton Keynes NHS FT	6.0	7.3	(1.3)	23.5	25.0	(1.5)
BLMK ICB	0.0	0.0	0.0	1.6	1.6	0.0
Total	**43.1**	**37.8**	**5.2**	**141.8**	**144.2**	**(2.5)**

- BHFT is reporting a £6.5m underspent year to date, mainly due to outside of envelope schemes. The Trust is forecasting an overspend on capital against the original plan by £1.0m. This is due to approval of the additional theatre on the Bedford site, funded from the Targeted Investment Fund. As above additional national funding is anticipated to cover the forecast position. Performance against CDEL limit is forecast to be breakeven.
- Milton Keynes Hospital is reporting a year-to-date overspend, which is due to the timing of the Maple Centre. The Trust is forecasting this will become a £1.5m deficit by the end of the year and relates to donated capital, which is excluded from CDEL. Performance against CDEL limit is forecast to be breakeven.
- The ICB has been allocated capital funding of £1.6m to support GP IT and corporate capital. The Integrated Care Board is reporting no spend year-to-date but forecasts to spend this allocation in full. Capital expenditure on GP IT is capitalised by NHS England rather than the Integrated Care Board. All ICB capital is therefore subject to NHS England business case processes and only released when business cases are approved.

6.0 Recommendations

6.1 The Integrated Care Board is asked to:

- Note the year-to-date financial position of the ICS at month 6 and forecast position for revenue and capital
- Note the risks to the financial forecast

Appendix A

Financial Position of ICS Local Authority Partners

A summary of the financial position of Local Authorities is set out below:

Bedford Borough Council: The authority faces a wide number of challenges to the provision of its services in the current year resulting in a forecast overspend position of £6.5 million by the end of the financial year.

Services are being delivered against a backdrop of significant inflationary pressures (upward pay pressures, energy/ commodity prices and wider contract inflation) resulting from the war in Ukraine and wider geopolitical issues affecting supply chains. There are specific financial pressures in Children's Services. This is due to an increase in numbers of children's placements, particularly in residential care, together with an increase in the complexity of their needs. The demand and cost of school transport is also impacting on the financial position. Further pressures also exist in relation to housing and the supply of temporary accommodation.

The Authority is taking steps to manage and minimise the overspend in so far as is possible, to reduce the overspend by the end of the financial year.

Central Bedfordshire Council: As at the end of September, forecasting a gross overspend of £10.7m.

The main drivers of the overspend are in Children's Services, being the cost of education transport and the cost of individual placements (fostering and adoption etc) and the effects of Covid in terms of social work cases coming through and the impact on leisure income and car parking.

However, after application of budget contingency and Covid and financial hardship related grants, the Council is forecasting achievement of a balanced outturn position.

Luton Borough Council: Forecast overspend of £10.1m indicated for General Fund Services at the first Quarter's monitoring, after the use of the general contingency budget and some specific reserves.

The adverse position reflects the impact of price inflation, the enduring impact of covid and delivery risks regarding the budgeted savings programme.

Recovery actions have been put in place with the aim to reduce the current forecast overspend to a balanced position by the end of the year and for improving the prospects for the 2023/24 Budget.

Milton Keynes: At the end of September 2022, the Council was forecasting an overspend of £2.8m. The key pressures are within:

- Adult Services with Adult Social Care forecast to overspend by £1.8m;
- Children's Services with Children's Social Care is forecast to overspend by £2.2m;
- Environment and Property - forecast overspend of £0.9m, including rising inflation £1.2m for utilities, including street lighting and highways contract £0.4m and our Environmental Services Contract of £0.4m;
- Increased pay award (now agreed) has added an additional £3.9m to the overspend compared with the 2% allowance that was included in the budget;
- Overspends have been partly reduced through increased investment income (higher interest rates) of £3.7m, parking income of £1.25m and additional grant income of £0.5m.

After all corporate items including the use of full contingency, the overspend is projected at £2.785m, which is being funded from uncommitted earmarked reserves.

Glossary of commonly used terms in Finance reports

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

MKUHFT	Milton Keynes University Hospital NHS Foundation Trust	
NHSE	NHS England	
SDF	System Development Funds	Resource allocations for specific programme activities deemed a priority by NHSE for 2022/23.
YTD	Year-To-Date	

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
17. – Board Assurance Framework

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	Ola Hill, Deputy Head of Organisational Resilience
Date to which the information this report is based on was accurate	9th November 2022
Senior Responsible Owner	Maria Wogan, Chief of System Assurance and Corporate Services

The following individuals were consulted and involved in the development of this report:
Maria Wogan, Chief of System Assurance and Corporate Services
This report has been presented to the following board/committee/group:
Not applicable

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

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

A) Progress against the Board Assurance Framework Workplan
B) Feedback from Board Development Session on 4th November
C) Next steps in the Board Assurance Framework Workplan

1. Brief background / introduction:

BLMK ICB's vision for risk management is for all decision makers to be fully informed of risk and that risks are effectively managed in the achievement of our objectives. Risk management benefits the ICB, our stakeholders and the local population by enabling new ideas to be explored and potential risks to be managed to minimise their impact. The approach is to utilise the ICB Board Assurance Framework (BAF) as the key tool to hold the strategic risks as defined by the ICB: the major risks that could prevent the ICB from fulfilling the objectives in its agreed strategy. These are strategic risks which pertain to the whole system as opposed to the ICB as a statutory organisation. Risks that pertain to the ICB as a statutory organisation are held on the ICB's corporate risk register and directorate sub-risk registers.

The development of the Board Assurance Framework is an iterative process engaging all the parts of the system to ensure that appropriate risks are identified and mitigated to support the ICB in achieving its objectives.

2. Summary of key points:

Progress with Board Assurance Framework Work Programme

Since the last meeting of the Board, the ICB Board Assurance Framework was presented to the System Oversight and Assurance Group on 27th September, where system leaders reviewed the Board Assurance Framework, assessing appropriateness and suitability and also, whether there are further risks to be added. The SOAG will act to collectively hold individual partners to account to ensure that system risks are effectively managed with actions being carried out at the most appropriate places in the system.

The ICB Executive Directors Meeting further reviewed the appropriateness and suitability of the current risks on the Board Assurance Framework on 19th October, noting the top risks to the system and changes in risk rating with regard to System Pressure & Resilience and System Transformation.

On 4th November, the Board focused on *Addressing Wicked Issues/Risks* as part of its Board Development Session, with a particular deep dive into the strategic workforce risk.

A System Risk Community of Practice has been established to co-design and co-produce an effective and efficient escalation and de-escalation process for system risks to the Board Assurance Framework from Trusts, Place and Neighbourhoods.

Current Board Assurance Framework

The Board Assurance Framework currently hold nine strategic system risks and there has been an increase to the risk rating of **BAF 3** as a result of increased pressure in the system threatening resilience and service delivery. The risk rating for **BAF 5** has also increased due to the pressure in the system reducing the capacity for transformation.

A summary of the Board Assurance Framework is below and is attached in full at Appendix A.

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

Addressing Wicked Issues/Risks - Board Development 4th November

With support from the Good Governance Institute, the Board reflected on the strengths of risk management at system level and how that was supportive of addressing multifactorial and complex risks (i.e. wicked issues). A collaborative deep-dive into the workforce risk (BAF 2) was also carried out, facilitated by Chief People Officer, Martha Roberts.

Feedback from the session was largely positive and as an outcome, the system Board Assurance Framework going forward will, through the System Risk Community of Practice, reflect risk mitigations that not only work at system level, taking advantage of the scale of the System but also work at place. The Audit and Risk Assurance Committee will also consider whether a strategic risk of 'failure to collaborate' should be added to the BAF and the outcome will be reported to the next Board meeting.

The deep-dive approach used in the session will be taken forward in Part 2 of the Audit & Risk Assurance Committee and at other Groups as a means of collaboration with regards to innovating actions that are agile and dynamic in support of mitigating complex system risks.

The Good Governance Institute commended the progress that the ICB has made to date with its strategic risk management programme and the governance that supports it. Most notable was the establishment of a two-part Audit & Risk Assurance Committee which managed the assurance to the Board around system risk management.

Next Steps in Work Programme

The System Risk Community of Practice will meet on 15th November with a view to co-producing the process that underpins the Board Assurance Framework and ensures that mitigations with a system view also work effectively at place.

The Audit & Risk Assurance Committee, at its meeting on 2nd December, will carry out a deep-dive into the Climate Change system risk to recognise mitigations already taking underway at place and support development of innovative future actions to support implementation of the Green Plan and further mitigation of the impact of the risk.

The mitigations and actions on the Board Assurance Framework will be reviewed by the SOAG at its meeting on 13th December, ensuring that they are appropriately owned within the system.

3. Are there any options?		
Not applicable		
4. Key Risks and Issues		
This report is wholly focused on risk		
Have you recorded the risk/s on the Risk Management system? Click to access system	Yes ☒	No ☐
The ICB Board Assurance Framework is wholly hosted on 4Risk.		
5. Are there any financial implications or other resourcing implications, including workforce?		
There are no direct financial or resourcing implications arising from this report. The ICB's Deputy Head of Organisational Resilience lead on strategic risk management as part of her wider Emergency Planning Resilience and Response portfolio equivalent to 0.5 WTE.		
6. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan		
Climate change is a key strategic system risk on the Board Assurance Framework.		
7. How will / does this work help to address inequalities?		
Reducing inequalities is a key strategic system risk on the Board Assurance Framework		
8. Next steps:		
• System Risk Community of Practice co-producing underpinning risk escalation and de-escalation process – 15th November • Audit & Risk Assurance Committee (Part 2) will deep-dive into Climate Change system risk – 2nd December		
9. Appendices		
Appendix A – ICB Board Assurance Framework		
10. Background reading		

BLMK ICB Board Assurance Framework

NHS
Bedfordshire, Luton and Milton Keynes

Report Date	11 Nov 2022
Risk Status	Open
Risk Area	0. ICB Board Assurance Framework
Comparison Date	In the past 3 Month(s)
Control Status	Existing
Action Status	Outstanding

Growth

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 6	Growth	Financial Sustainability & Underlying Financial Health **Risk Owner:** Dean Westcott **Risk Lead:** Stephen Makin **Last Updated:** 28 Oct 2022 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	As a result of increased inflation, significant operational pressures, patient backlogs and the enduring financial implications of the Covid pandemic - there is a risk to the underlying financial sustainability of BLMK that could result in failure to deliver statutory financial duties.	N/A To I = 5 L = 3 15	Monthly financial reporting to Finance & Investment Committee and Integrated Care Board - includes analysis of financial performance: revenue, capital, underlying financial performance plus risks & mitigations. System led financial oversight through SOAG, Performance & Delivery Group and System DoFs Update and development of system Medium Term Financial Plan for 2023/24 to 26/27. Includes scenario modelling of key variables and downsides.	N/A To I = 5 L = 3 15	Development and implementation of system transformation, improvement and efficiency programme covering for 2023/24 + across and between ICS partners **Person Responsible:** Anne Brierley **To be implemented by:** 31 Mar 2023	N/A To I = 4 L = 3 12
BAF 5	Growth	System Transformation **Risk Owner:** Anne Brierley **Risk Lead:** **Last Updated:** 04 Nov 2022 **Latest Review Date:** 23 Sep 2022 **Latest Review By:** Kathryn Moody **Last Review Comments:** Work continuing	There is a risk that sustained operational pressures and complexity of change, there will be reduced delivery and benefit from strategic transformational change to deliver improved outcomes for our population.	I = 4 L = 4 16 To I = 4 L = 4 16	Agreed strategic priorities across the system in place Chief Exec/SOAG - regular reviews of operational performance issues to agree mitigations EPRR Framework and System monitors and responds to incidents resulting from operational pressures to wider system Operational performance management process in place taking account of responses to operational pressures Performance & Delivery Group - manages immediate operational issues Same Day Urgent Primary Care Offer	I = 4 L = 3 12 To I = 4 L = 4 16	Establish delegation/migration programme to implement subsidiarity **Person Responsible:** Maria Wogan **To be implemented by:** 30 Sep 2022 Set clear timescales and expectations for place plans to deliver transformation for the population **Person Responsible:** Richard Alsop **To be implemented by:** 28 Oct 2022 Agree BLMK integrated care strategy including key metrics for population outcomes **Person Responsible:** Richard Alsop **To be implemented by:** 30 Dec 2022 Agree joint forward plan **Person Responsible:** Richard Alsop **To be implemented by:** 31 Mar 2023	I = 3 L = 2 6 To I = 3 L = 2 6

BLMK ICB Board Assurance Framework

Bedfordshire, Luton and Milton Keynes

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 2	Growth	Developing suitable workforce **Risk Owner:** Martha Roberts **Risk Lead:** John Syson **Last Updated:** 20 Oct 2022 **Latest Review Date:** 03 Nov 2022 **Latest Review By:** John Syson **Last Review Comments:** Underlying challenges relating to recruitment both domestically and internationally remain with significant shortfalls, particularly in qualified roles in multiple specialties e.g. Mental Health, Pharmacist, Midwives amongst others. Significant vacancies in care and health. Some success with recruitment and retention initiatives e.g. TNA & ARRS roles but at limited scale.	If system organisations within BLMK ICS are unable to recruit, retain, train and develop a suitable workforce then staff experience, resident outcomes and the delivery of services within the ICS, ICB People Responsibilities and the System People Plan are threatened.	I = 4 L = 5 20 To I = 4 L = 5 20	EDI & Wellbeing: People Board Sub Group focussing on supporting the wellbeing of staff across the ICS. Also responsible for improving workforce inequalities relating to protected characteristics and development and implementation of initiatives e.g. 'no more tick boxes' to address recruitment inequalities. Education Partnership: People Board Sub Group responsible for development and co-ordination of CPD fund use & demand scoping for system as well as use of apprenticeship levy, school and university engagement and development of innovate courses and training courses across health and care workforce Leadership & OD: People Board Sub Group focussing on building the OD capacity and skills within the system to support workforce transformation across health and care. Development of leadership and development programmes for the ICB and system partner organisations in conjunction with regional and national bodies. People Board: ICS Executive Group with responsibility for People Plan delivery to meet ICS workforce priorities linked to BAF and People Board workforce risks. This enables delivery of ICS Strategic Objectives, ICB People Responsibilities and development of Workforce strategy Primary Care Training Hub supporting in recruitment, retention and training of primary care	I = 4 L = 5 20 To I = 4 L = 5 20	Launch of 2 cohorts of Leading Beyond Boundaries (LBB) in 22/23: (Leadership & OD) launch complete a minimum of 2 cohorts of LBB programme in 22/23 **Person Responsible:** Martha **To be implemented by:** 30 Dec 2022 Launch, asses and embed the Health and Wellbeing pilot: (Primary Care) Pilot a range of wellbeing support and interventions for primary care staff, assess their impact and embed those which represent value to the system. **Person Responsible:** Susi Clarke **To be implemented by:** 31 Mar 2023 Rotational Apprenticeship: (Education Partnership) Pilot of level 3 HCA rotational apprenticeship between health and care providers in Bedfordshire to launch in 22/23 as proof of concept **Person Responsible:** Catherine Jackson **To be implemented by:** 31 Mar 2023 50k Nursing Target: (linked to Workforce Modelling and Supply) System has a target to increase NHS system nurses WTE to in excess of 3113WTE by March 2023. Sources range from international recruitment, apprenticeships to graduates and those recruited from other systems. **Person Responsible:** Marie Lambeth -Williams **To be implemented by:** 31 Mar 2023	I = 4 L = 3 12 To I = 4 L = 3 12

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
					Primary Care: People Board Sub Group focussing on workforce programmes as they relate to Primary Care Workforce. Wellbeing, career development, new roles (e.g. ARRS), international recruitment and workforce planning and OD Workforce Modelling & Supply: People Board Sub group focussing on the development of workforce strategy, recruitment, retention programmes and innovative role		Embed use of 'No more tick boxes' recruitment approach: (EDI & Wellbeing) To ensure that system organisations have implemented the key principals of the 'no more tick boxes' approach to recruitment in at least some recruitment episodes in 22/23 **Person Responsible:** Martha **To be implemented by:** 31 Mar 2023	

Live Well

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 9	Live Well	Rising Cost of Living **Risk Owner:** Maria Wogan **Risk Lead:** Martha Roberts **Last Updated:** 25 Oct 2022 **Latest Review Date:** 23 Sep 2022 **Latest Review By:** Kathryn Moody **Last Review Comments:** requires further clarification in terms of actions required. To be worked through with RA.	As a result of rising cost of living there is a risk that our staff and residents will not be able meet their basic needs resulting in deteriorating physical and mental health resulting in pressure on all public services	N/A To I = 4 L = 4 16	Communications plan to support population access to support services Partner plans for managing increased costs due to inflation Partner support schemes for residents Partner Support Schemes for staff	N/A To I = 4 L = 4 16	Understand and promote partner support schemes for residents **Person Responsible:** Maria Wogan **To be implemented by:** 30 Nov 2022 [EDI & Wellbeing People Sub-Group]: Maximise support for staff across BLMK **Person Responsible:** Martha **To be implemented by:** 30 Dec 2022 Agree medium-term financial plan with NHS partners **Person Responsible:** Dean Westcott **To be implemented by:** 31 Mar 2023	N/A To I = 3 L = 4 12

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 7	Live Well	Climate Change **Risk Owner:** Maria Wogan **Risk Lead:** Tim Simmance **Last Updated:** 10 Nov 2022 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	Due to climate change and wider impacts on the environment and biodiversity, there is a significant risk of increased pressure on health and care services, due to: i) exacerbation of existing health conditions (e.g. CVD, COPD, Asthma, mental health); ii) new health challenges (e.g. tropical disease prevalence, population migrations); iii) extreme weather events resulting in harm (e.g. storms, floods, wildfires); iv) disruption to day-to-day healthcare provision (e.g. supply chain, workforce availability, power outages, infrastructure damage); and v) a deterioration in population health outcomes. This risk is materialising now, in some contexts, and will increase in both likelihood and severity as climate change progresses.	N/A To I = 4 L = 4 16	BLMK ICS Green Plan 2022-25 Create and implement Adaption Plan (as part of the ICS Green Plan) - to include both mitigations for likelihood and impact of the risks posed by climate change, including alternate ways to deliver services to reduce their vulnerability to climate change. Local Resilience Forum Adverse Weather Plans Partner Green Plans and Sustainability Plans. NHS organisations, local authorities and other public sector bodies have plans to reduce their contribution to climate change, and put in place both business continuity and adaptation plans to address the impacts of climate change. The ICB will support NHS providers to implement their green plans and ensure adaptation plans are in place, and work in partnership with other public sector bodies and anchor institutions to mitigate the risks of climate change. Severe Weather Plan	N/A To I = 4 L = 4 16	Develop and begin implementation of the delivery plan high impact elements of the BLMK ICS Green Plan (including supply chains, estates, medicines, care model transformation), linking with sustainability plans in partner organisations (including local authorities, NHS Trusts, other anchor organisations), to reduce the impact of healthcare on the climate and other environmental concerns. **Person Responsible:** Tim Simmance **To be implemented by:** 31 Jan 2023 Identify a BLMK ICS lead, who will then oversee creation, approval and delivery of a BLMK system-wide, healthcare Adaptation Plan, outlining how the system and services will work to increase resilience to the effects of climate change. **Person Responsible:** Tim Simmance **To be implemented by:** 31 Mar 2023 Support review of business continuity arrangements of ICS partners to ensure forward planning to manage climate change-related incidents. **Person Responsible:** Abimbola Hill **To be implemented by:** 31 Mar 2023	N/A To I = 2 L = 4 8

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 8	Live Well	Population Growth **Risk Owner:** Anne Brierley **Risk Lead:** **Last Updated:** 20 Oct 2022 **Latest Review Date:** 23 Sep 2022 **Latest Review By:** Kathryn Moody **Last Review Comments:** on track	As a result of fast rate of population growth in BLMK, there is a risk that our infrastructure will not keep pace with the needs of our population, which will exacerbate widening inequalities and outcomes.	N/A To I = 4 L = 4 16	Local Authority Place Plans Oxford-Cambridge Arc	N/A To I = 4 L = 4 16	Develop and approve BLMK Health and Care Partnership Integrated Care Strategy **Person Responsible:** Richard Alsop **To be implemented by:** 30 Dec 2022	N/A To I = 2 L = 4 8

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 1	Live Well	Recovery of Elective & Cancer Services **Risk Owner:** Anne Brierley **Risk Lead:** Michael Ramsden **Last Updated:** 20 Oct 2022 **Latest Review Date:** 23 Sep 2022 **Latest Review By:** Kathryn Moody **Last Review Comments:** On track and well documented	There is a risk that the NHS is unable to recover elective and cancer services and waiting times to pre-pandemic levels due to Covid and Urgent and Emergency Care pathway related pressures, workforce constraints or demand led pressures. This may lead to poorer patient outcomes and reputation damage.	I = 4 L = 4 16 To I = 4 L = 4 16	1. All Trusts have recovery action plans. 2. Changes made to L&D Endoscopy service so referrals through one route (Referral Assessment Service) where clinical triage occurs. 3. Change in national guidance for aerosol generation procedures leading to improvement in capacity 4. Significant increase in Endoscopy capacity.However still a high number of patients waiting and cancer demand increasing. 5. Clinical Prioritisation of wait list across BLMK. Reduction in Long waits with elimination of 104ww and 78ww in 22/23 6. Cancer 62 day backlog recovery action plans and revised trajectory of improvement An Elective Recovery Board has been convened to track recovery and instigate actions. The Board involves CEO/executive/senior stakeholders across commissioning, providers & NHSEI and is accountable for delivery of the Elective Transformation Programme and Elective Accelerator Programme in Bedfordshire, Luton and Milton Keynes. It sets the vision and change needs to deliver the programme objectives whilst assuring quality, safety and value for the BLMK Monthly RTT report indicating size of waiting list and length of wait. Ongoing work with hospitals to optimise utilisation of ISP's Clinical Prioritisation (P1-6) review and shared decision making in place	I = 4 L = 4 16 To I = 4 L = 4 16	Maintain oversight of the 22/23 Operational Plan delivery. All actions will support recovery of Elective performance and will be monitored through the Elective Collaboration Board **Person Responsible:** Michael Ramsden **To be implemented by:** 31 Mar 2023 System wide transformation plan to increase productivity using GIRFT data); transform outpatients through advice and guidance, PIFU and virtual clinics; demand management actions such as clinical triage. All outlined in the 22/23 Operational Plan and delivery overseen by the Elective Collaboration Board **Person Responsible:** Michael Ramsden **To be implemented by:** 31 Mar 2023	I = 4 L = 3 12 To I = 4 L = 3 12

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
					Monthly RTT report indicating size of waiting list and length of wait. Ongoing work with hospitals to optimise utilisation of ISP's Processes in place to ensure those with most urgent clinical needs are treated first. Quality - Supporting review of performance across service provision in particular Cancer services and associated Pathways & diagnostics. Triangulating information and soft intelligence such as serious incidents , complaints , HW engagement , Safeguarding partnership information. Involvement in ICS board discussion for MH , Stroke , Cancer, safeguarding The actions and controls to support the Pandemic and System Pressures risk will support Elective Recovery, as, if there is strong demand management and flow, then the likelihood of emergency medical patients outlying to surgical ward (and concomitant elective cancellation) will be mitigated.		06/09/2022 - AGEM unable to forecast demand and capacity due to issues with the national tool. Signficant delays therefore expected in 22/23. Work continues to develop a useful forecast for 23/24 planning round Demand and Capacity modeling. Working with AGEM CSU to develop a model. 04/02/2022 - now to include the Strategic Planning Tool 05/04/2022 - Deloittes have undertaken D+C analysis for BLMK. The draft report is being reviewed at the Elective Collaboration Board in April where further actions will be agreed. To remain open until report is signed off as accurate. D+C data will need periodic refreshes which will be undertaken by AGEM 17.7.21 - Due to national issues with the Strategic Planning Tool, the Elective Board agreed to revert to a manual process for Demand and Capacity Modelling in 22/23. Further updates to be presented to the Elective Board throughout the year **Person Responsible:** Michael Ramsden **To be implemented by:** 31 Mar 2023	

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 3	Live Well	System Pressure & Resilience **Risk Owner:** Richard Alsop **Risk Lead:** **Last Updated:** 04 Nov 2022 **Latest Review Date:** 19 Oct 2022 **Latest Review By:** Abimbola Hill **Last Review Comments:** Current likelihood increased due to current system pressures.	As a result of continued pressure on services from various factors (staff sickness, increased activity etc) there is compromised resilience in the health and social care system which threatens delivery of services across BLMK. This may lead to poorer patient outcomes and reputational damage.	I = 4 L = 5 20 To I = 4 L = 5 20 	BLMK engaged with regional critical care groups BLMK Primary Care Access Program CCG officers review performance weekly via reset & restoration meetings Discharge To Assess process is being implemented in Bedfordshire (already in place in Milton Keynes Established a cell approach to manage the ongoing Covid incident with an associated ICC incident control centre, reports are provided via the monthly EPRR Overview & Scrutiny Group and onwards to the GB In line with escalation process, daily system calls in place for Bedfordshire Increased Patient Transport Services to facilitate swifter discharge Monthly reports are reviewed at the TILT, Q&P and F&P meetings and the GB Reports are provided to the ICS CEO meeting regarding the performance issues and Covid position Revised escalation process in place to prompt system response across BLMK SHREWD being implemented across BLMK to enable real time resilience/flow data. Specific CCG focus on community bed management across Bedfordshire.	I = 4 L = 4 16 To I = 4 L = 5 20 	EPRR Lessons Learned Exercise built into future management of **Person Responsible:** Mark Meekins **To be implemented by:** 30 Dec 2022 Continued development and implementation of support/access improvement projects via BLMK Access Group and sub-groups **Person Responsible:** Nicky Poulain **To be implemented by:** 28 Apr 2023	I = 4 L = 4 16 To I = 3 L = 4 12 

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
					The Health Cell (now BLMK Performance & Delivery Group) reviews performance on a bi-monthly basis and agrees system mitigations and actions The TILT reviews performance on a monthly basis Winter Planning to include commissioning of further capacity (beds and care) across BLMK Work with Councils to review and redesign care pathways to release more therapy resource to focus on flow.			

Reduce Inequalities

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 4	Reduce Inequalities	Widening inequalities **Risk Owner:** Anne Brierley **Risk Lead:** **Last Updated:** 20 Oct 2022 **Latest Review Date:** 23 Sep 2022 **Latest Review By:** Kathryn Moody **Last Review Comments:** Timelines to be confirmed with NW/HT	There is a risk that inequalities and outcomes for specific demographic groups within BLMK population will widen (e.g. cost of living, health and care demand pressures) compromising our ICS purpose to improve outcomes and tackle inequalities.	I = 4 L = 4 16 To I = 4 L = 4 16	Cross-ICS inequalities steering group and working group to coordinate inequalities activity across the ICS framed around the core20plus5 approach ICS system inequalities lead appointed giving more capacity for this workstream Learning from incidents , safeguarding case review, Community partnership safety work Resource allocation for 22/23 to help to reduce inequalities and draw out learning for future investment Review to understand the impact of Covid on inequalities (Lloyd Denny) Literature review completed. Safeguarding partnership board priorities (Neglect , transition etc..) Working with providers and partners on access for seldom heard communities Supporting the workforce to deal with the impact of the pandemic being overseen by the BLMK Peoples Board. The new PCN Impact Investment Fund (criteria released 24.08.21) states that by 31 March 2022, PCNswill make use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and develop and implement a plan to improve access for these patient groups.	I = 4 L = 4 16 To I = 4 L = 4 16	Linking to Place plans, each place profile will highlight inequalities and agree appropriate actions (Executive leads appointed for each Place). Version 2 of place plans in development. Work ongoing **Person Responsible:** Nicky Wadely **To be implemented by:** 28 Oct 2022 Assurance and outcome metrics to be developed by Inequalities lead **Person Responsible:** Hilary Tovey **To be implemented by:** 28 Oct 2022	I = 4 L = 3 12 To I = 4 L = 3 12

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
					Work with voluntary agencies e.g maternity Voices , parent carer forums SEND in coproduction of			

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Report to the Board of the Integrated Care Board
18. Governance Update

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

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

Report Author	Maria Wogan, Chief of System Assurance & Corporate Services Gaynor Flynn, Governance & Compliance Manager
Date to which the information this report is based on was accurate	11.11.2022
Senior Responsible Owner	Maria Wogan, Chief of System Assurance & Corporate Services

The following individuals were consulted and involved in the development of this report:
▪ Maria Wogan, Chief of System Assurance and Corporate Services ▪ Stephen Makin, Deputy Chief Finance Officer ▪ Individual Funding Request Team
This report has been presented to the following board/committee/group:
None. The reports from Committees summarise the outcomes of the meetings of the Committees of the ICB.

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

This paper proposes some amendments to the ICB's governance handbook in relation to:

- Individual Funding Requests (IFRs)
- An additional member to the Terms of Reference of the Primary Care Commissioning and Assurance Committee
- Delegated limits
    - Revenue Spend Continuing healthcare (Continuing Health Care – Adult & Children's) & Special Packages – Mental Health/Learning Difficulties & Autism including Section 117/Specialist Placements approval
    - Corporate / Non-Healthcare related Invoices
    - Commissioned Healthcare Invoices
    - Capital Expenditure (ICB Only)
    - Non-Healthcare Contracts
    - Healthcare Contracts
- Committee appointments

The report also summarises the outcomes of the recent meetings of the Committees of the ICB and provides the minutes of those meetings for the Board to note.

Members are asked to:

A) **Approve** delegation for approval of arrangements for managing Individual Funding Requests to the Quality & Performance Committee – see 2.1 below.

B) **Approve** amendments to the following sections of the Governance Handbook:
- Scheme of Reservation and Delegation – see 2.2 below.
- Quality and Performance Committee Terms of Reference – see 2.3 below.
- Detailed schedule to operational / financial scheme of delegation – see 2.4 below & appendix A.
- Primary Care Commissioning and Assurance Committee Terms of Reference – see 2.5 below.

C) N**ote** the following:
- Committee appointments – see 2.6 below.
- Committee Chairs updates and minutes – provided in Appendix B.

A link to the ICB's Governance Handbook can be found in section 10 below.

Executive Summary Report

1. Brief background / introduction:

As expected, there is a need to adjust some of the ICB's governance arrangements in the light of the first few months experience of operating the new organisation. Approval of amendments to the ICB's Governance Handbook is a power reserved to the Board of the Integrated Care Board.

2. Summary of key points:

2.1 Individual Funding Requests (IFR)

Following the transition to the ICB there are some process and governance issues that need to be addressed to put in place a sustainable, effective and robust process for the management of IFRs.

Currently approval of arrangements for managing Individual Funding Requests is a function reserved to the Board. It is recommended that the Board agree to delegate this function to the Quality & Performance Committee.

If this recommendation is approved, it will be reflected in the Scheme of Reservation & Delegation and the Quality and Performance Committee Terms of Reference as noted below.

An amendment to the Detailed Scheme of Delegation is also recommended in relation to IFRs and is covered in 2.4 below.

2.2 Scheme of Reservation and Delegation
(See page 117 & 121 of the ICB's Governance Handbook)

Subject to the recommendation in 2.1 above there will be a requirement to amend the Scheme of Reservation and Delegation to reflect this as follows:

	Decisions and functions reserved to the Board
~~The Board~~	~~Approve arrangements for managing Individual Funding Requests~~

Committee	Decisions and functions delegated to the Committee
Quality and Performance Committee	To oversee arrangements for managing Individual Funding Requests

2.3 Quality and Performance Committee Terms of Reference
(See page 35 of the ICB's Governance Handbook)

Subject to the recommendation in 2.1 above it is recommended that the following responsibility be inserted into the Quality and Performance Committee Terms of Reference.

> 'To receive an annual report from the Exceptional Cases Panel covering the number of cases considered, case outcomes, alongside any issues and risks arising'

2.4 Detailed operational / financial scheme of delegation
The following amendments are recommended for approval by the Board and are listed in detail in Appendix A. They are supported by the ICBs Finance Team and approved by members of the Audit & Risk Assurance Committee.

- IFR has been added as a separate section (this is following discussions with the IFR Team and with approval from Finance).
- Continuing Health Care (CHC – Adult & Children's) & Special Packages – Mental Health / Learning Disabilities & Autism including Section 117/Specialist Placements approval limits have been increased in line with feedback from operational teams that previously limits were unworkable because they had been set too low. For context, the CCG had not previously set limits within its SFIs in this area. We will continue to monitor the limits and determine whether the limits need to be further adjusted at a later date.
- A new limit has been added for Band 8c related to Corporate / Non-Healthcare Related In-voices, adding in a limit of £10k to reflect operational feedback.
- A new section has been added for capital.
- The tendering and contract limits have been adjusted to align with the ICB updated Single Tender Waiver Form.

2.5 Primary Care Commissioning and Assurance Committee Terms of Reference
(See page 60 of the ICB's Governance Handbook)

Following review of the Primary Care Commissioning and Assurance Committee membership it is recommended that an additional Member is added. This requires the following amendment to be made to the committees Terms of Reference (highlighted in grey):

Members with Voting rights:

a) Non-Executive Member (Chair)
b) Non-Executive Member
c) ICB Chief Executive Officer
d) ICB Chief Primary Care Officer
e) ICB Chief Finance Officer
f) ICB Chief Nursing Director
g) ICB Chief Medical Director
h) At least two Clinical Representatives

2.6 Committee appointments

- Exceptional Cases Panel - Chair
  - Mahesh Shah, Primary Medical Services (provider partner member of the Board of the ICB.
- Remuneration Committee – Non-Executive Deputy Chair
  - To be confirmed following 25.11.22 Remuneration Committee meeting.
- Working With People and Communities - representatives from Voluntary, Community & Social Enterprise (VCSE):
  - Ben Thomas, Citizens Advice Milton Keynes
  - David Morris, New Opportunities and Horizons (NOAH), deputy VCSE representative
  - Diana Blackmun, Central Bedfordshire Council

3 Are there any options?

Approval of amendments to the ICB's Governance Handbook is a power reserved to the Board of the Integrated Care Board.

4 Key Risks and Issues

Individual Funding Requests - following the transition to the ICB there are some process and governance issues that need to be addressed to put in place a sustainable, effective and robust process for IFR.

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

Currently in the process of being added to 4Risk.

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

None identified.

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

Click to view Green Plan

Not applicable.

7 How will / does this work help to address inequalities?
Not applicable.
8 Next steps:
The Governance Handbook will be updated and re-published on the Integrated Care Board website.
9 Appendices
Appendix A - Detailed operational / financial scheme of delegation. Appendix B - Committee Chairs updates and minutes.
10 Background reading
The ICBs Governance Handbook - nhs-blmk-icb-governance-handbook-final-v2-0

Appendix A

Detailed Operational / Financial Scheme of Delegation

Ref	Matter Delegated	Delegated to
A	**Revenue Spend Continuing healthcare (CHC – Adult & Children's) & Special Packages - MH/LD & Autism including S117/Specialist Placements approval (weekly limits)**	
	Package approval - to £1,500 per week	CHC / S117 / Specialist Placements Team (Band 8a)
	Package approval – to £2,500 per week	CHC / S117 / Specialist Placements Team (Band 8b)
	Package approval - to £4,000 per week	CHC / S117 / Specialist Placements Team (Band 8c)
	Package approval - to £6,500 per week	Associate Director / Service Director
	Package approval - to £10,000 per week	Executive Director
	Package approval - above £10,000 per week	Chief Executive and Chief Finance Officer (jointly)
B	**Individual Funding Requests (On the advice of the Exceptional Cases Panel)**	
	Package approval - up to £50k	Deputy or Associate Director (Band 8d)
	Package approval - up to £100k	Chief Transformation Officer or Chief Medical Director
	Package approval - above £100k	Chief Finance Officer or Chief Executive Officer (jointly)
C	**Authorisation of invoices (in Oracle)** - relating to commissioning healthcare expenditure under service level agreements, contracts or partnership agreements. This may include non-commissioning expenditure included within NHS contracts - where this is the case, ensure appropriate approval from the relevant Budget Holder as well as the below. In line with budget management responsibilities (i.e. delegated budgets) and subject to quoting and tendering requirements.	

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	Corporate / Non-Healthcare related Invoices Limits for invoice approvals, includes professional services i.e. legal advice, specialist advice, specific projects (all values are inclusive of VAT irrespective of whether this is reclaimable or not):	
	To £10,000	Band 8c
	to £25,000	Associate and Deputy Directors (Band 8d and above)
	to £100,000	Executive Directors
	to £250,000	Chief Transformation Officer, Director of Commissioning, Director of Contracting, Deputy CFO
	to £1,000,000	CFO
	Greater than £1,000,000	Chief Executive
	Commissioned Healthcare Invoices	
	to £25,000	Contract Manager (Band 8a)
	to £50,000	Senior Manager (Band 8b and above)
	to £200,000	Senior Manager, Associate Director (Band 8c)
	to £5,000,000	Associate Director, Deputy Director (Band 8d and above)
	to £25,000,000	Executive Director, Director or Deputy CFO
	to £50,000,000	CFO or Chief Transformation Officer
	Greater than £75,000,000	Chief Executive

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	Continuing Healthcare / S117 / Specialist Placement invoices: ***It is not anticipated that invoice values will exceed the limits detailed below:***	
	to £5,000	Band 8a (CHC / Mental Health Teams)
	to £10,000	Band 8b (CHC / Mental Health Teams)
	to £50,000	Band 8c (CHC / Mental Health Teams)
	to £100,000	Associate Director
	to £250,000	Relevant Service Director
D	**Signing of Contracts** ***Signing of contracts, including contract variations and letters of intent (the below is based on the lifetime value of the contract).***	
	Non-Healthcare Contracts: to £100,000	Executive Director, Director of Commissioning, Director of Contracting, Deputy Chief Finance Officer
	to £500,000	CFO
	to £1,000,000	Chief Executive
	Greater than £1,000,000	Chief Executive & CFO (jointly)
	Healthcare Contracts: to £25,000,000	Executive Director, Director of Commissioning, Director of Contracting
	to £100,000,000	CFO or Chief Transformation Officer

	to £500,000,000	Chief Executive
	Greater than £500,000,000	Chief Executive & CFO (jointly)
E	**Off-payroll / agency workers** ***Non-clinical agency roles are subject to NHS England controls and will need to be approved by the NHS England Regional Team***	
	Approval requirements to appointment off-payroll and agency workers: Less than £400 per day and less than three months engagement	 Executive Director *Non-clinical agency subject to NHSE approval*
	Less than £600 per day and less than six months engagement	Executive Management Team *Non-clinical agency subject to NHSE approval*
	Less than £600 per day and greater than six months (including where initial arrangements were for less than six months and have then been extended to greater than 6 months)	Executive Management Team *Non-clinical agency subject to NHSE approval*
	More than £600 per day	Executive Management Team *Non-clinical agency subject to NHSE approval*
	Authority to appoint staff not on the formal establishment	CFO and AO
F	**Consultancy Expenditure** ***Consultancy is subject to NHS England controls***	
	Approval requirements for consultancy spend: to £49,999	 Executive Management Team
	£50,000 and above	Executive Management Team plus NHS England approval

G	Emergency Response	
	The Department of Health and Social Care defines a major incident as “an event or a situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK.”	The Oncall Manager and the Second Oncall Manager have delegated authority to make urgent financial decisions relating to the CCG within the CCG unit of planning and other NHS organisations within the health community as appropriate during a major incident.
H	**Capital Expenditure (ICB Only)** These limits relate to capital expenditure incurred by the ICB on behalf of NHS England in respect of GPIT and Primary Care Estates and ICB Corporate Capital. Capital Business Cases relating to GP IT and Primary Care Estates currently require counter approval by NHS England via the East of England Regional Capital & Investment Oversight Group (CIOG)	
	Up to the ICB Capital Resource Limit as designated by NHS England	Chief Executive or Chief Finance Officer following approval of the annual capital plan by the Integrated Care Board (following recommendation by the Finance & Investment Committee)
I	**Tendering and Contracting** Limits for quotes and tenders (all values are inclusive of VAT irrespective of whether this is reclaimable or not and apply to the total contract duration). The ICB ▪ Will ensure proper competition that is legally compliant within all purchasing to ensure we incur only budgeted, approved and necessary spending ▪ Will seek value for money for all goods and services	
	NON-HEALTHCARE CONTRACTS	

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	Formal tendering procedures need not apply where estimated expenditure does not or is not reasonably expected to exceed £50,000 over the whole life of the contract.	
	£10,000 to £20,000	A minimum of 2 written competitive quotations must be obtained for: ▪ all building and engineering works, ▪ goods, ▪ equipment, and ▪ services Managers are required to hold evidence of quotations for audit While no formal process is required although best value for money should be sought at all times and purchases should be from a reputable source.
	£20,001 to £50,000	A minimum of **3** written competitive **quotations** to be obtained for ▪ all building and engineering works, ▪ goods, ▪ equipment, and ▪ services Managers are required to hold evidence of quotations for audit While no formal process is required although best value for money should be sought at all times and purchases should be from a reputable source.
	£50,001 and above, but below the Public Contract Regulation Thresholds	If expenditure is likely to exceed £50,000 a formal tendering process must be followed in accordance with the ICB Procurement Policy. If there is a valid reason for not following the formal process (see list of exemptions below) a Single Tender Waiver request form must be completed.

	Equal to or above the Public Contract Regulation Threshold applicable at the time	Compliance with the Public Contract Regulations 2015. Advice to be sought from the Chief Transformation Officer and Procurement Advisors.
	HEALTHCARE CONTRACTS *Formal tendering procedures need not apply where estimated expenditure does not or is not reasonably expected to exceed £250,000 over the whole life of the contract.*	
	£10,000 to £20,000	A minimum of **2** written competitive **quotations** must be obtained. Managers are required to hold evidence of quotations for audit While no formal process is required although best value for money should be sought at all times and purchases should be from a reputable source.
	£20,001 to £50,000	A minimum of **3** written competitive **quotations** to been obtained. Managers are required to hold evidence of quotations for audit While no formal process is required although best value for money should be sought at all times and purchases should be from a reputable source.
	£50,001 to £250,000	A minimum of **5** written competitive **quotations** to be obtained (although it is recognised that these may not all be returned). Managers are required to hold evidence of quotations for audit

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		While no formal process is required although best value for money should be sought at all times and purchases should be from a reputable source.
	£250,001 to Public Contract Regulation Threshold (applicable at the time)	For expenditure exceeding £250,000 and below the Public Contract Regulation Threshold (as applicable at the time) - a formal, proportionate and transparent process should be agreed with procurement advisors and carried out in accordance with the ICB Procurement Policy. If there is a valid reason for not following the formal process (see list of exemptions below) a Single Tender Waiver request form must be completed.
	Equal to or above the Public Contract Regulation Threshold (applicable at the time)	If expenditure is likely to exceed the Public Contract Regulation Threshold (as applicable at the time), a formal tendering process must be followed in accordance with the ICB Procurement Policy. If there is a valid reason for not following the formal process (see list of exemptions below) a Single Tender Waiver request form must be completed.

Exceptions and instances where formal tendering need not be applied

Formal tendering procedures need not be applied where:

- as outlined above
- where the supply is proposed under special arrangements negotiated by the Department of Health or NHS England in which circumstance such special arrangements must be complied with

Deleted: <#>The planned expenditure or income does not, or is not reasonably expected to, exceed £50,000 including VAT (regardless of whether recoverable).¶

Formal tendering procedures may be waived by the prior joint agreement of the Chief Executive and the Chief Finance Officer in the following circumstances:

(a) In very exceptional circumstances where the Chief Executive or Chief Finance Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate ICB record;
(b) where the requirement is covered by an existing contract;

(c) where NHS Supply Chain or equivalent agreements are in place and have been approved by the ICB Board;
(d) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
(e) where the timescale genuinely precludes competitive tendering – note that failure to plan properly shall not be regarded as a justification for a single tender;
(f) where specialist expertise is required but is only available from a single source;
(g) when the task is essential to complete a project, and arises as a consequence of a recently completed assignment and engaging different contractors for the new task would be inappropriate;
(h) when there is a clear benefit to be gained from maintaining continuity with an earlier project – in such cases the benefits of such continuity must demonstrably outweigh any potential financial advantage to be gained by competitive tendering;
(i) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the ICB is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and is generally recognised as having sufficient expertise in the area of work for which they are commissioned (the CFO shall ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work);
(j) where allowed and provided for in the Capital Investment Manual.

The waiving of competitive tendering procedures shall not be used to avoid competition or for administrative convenience, or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate ICB record and formally reported to the Audit & Risk Assurance Committee.

The Director of Contracting will issue documentation to be used to request any waiver under this clause, and record approval thereof.

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NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Appendix B – Committee Chairs' Updates

Audit & Risk Assurance Committee Part 2 2-09-2022
Update to Board on key points
▪ Update from this meeting was given at last Board meeting but draft minutes were not available. These are now attached.
Decisions for approval by the Board
▪ There are none.

Bedfordshire Care Alliance
Update to Board on key points
▪ There is no further update since the last meeting.
Decisions for approval by the Board
▪ There are none

Finance & Investment Committee 17-10-2022
Update to Board on key points
▪ The Committee received and noted both the ICB and System finance reports for month 5, and that the current forecasts are for year-end breakeven. ▪ The Committee received a progress update on the System Medium Term Financial Plan and noted that a further update will be presented at the next meeting on 9th December. ▪ The Committee received an update on the status of the ICB key NHS contracts for 2022\23 and noted the work and progress to conclude outstanding issues in relation to out of system associate contracts. ▪ The Committee received an update on the system capital position and progress on key projects including the North Bedfordshire Hub Scheme. The Committee also discussed the draft Community Diagnostic business case and in particular how such cases can be designed to support the key ICB objective of reducing health inequalities going forwards.
Decisions for approval by the Board
▪ There are none

Health & Care Senate 6-10-2022
Update to Board on key points
Musculoskeletal Services (MSK) Health Needs Assessment (HNA) ▪ The Senate noted the HNA, specifically the role of community pharmacy and dentistry. The next meeting of the Senate will focus on poly-pharmacy, falls and digital intervention. ▪ A separate meeting is also being arranged re Falls to involve Quality Team, Community Healthcare Services and Fire Service as part of the Winter Resilience work. **Head and Neck Cancer Services in MK:** ▪ The Senate supported the proposed model for Head and Neck Cancer services in MK and agreed to send a letter from the Senate to Specialist Commissioning supporting the proposal. ▪ The Senate noted the concerns around patient safety and the measures put in place to try and mitigate these concerns, including fail safe officers.

- Outside of the meeting further research around the parity of mental health and physical health services will be explored along with the work around the transformation programme and also consider the impact of health inequalities.

Decisions for approval by the Board

- There are none

Health & Care Partnership 21-09-2022
Update to Board on key points
▪ Rima Makarem was appointed as the Deputy Chair of the Health and Care Partnership ▪ An update on the development of the Integrated Care Strategy was provided and it was agreed that iterations of the strategy would be circulated to the Partnership members for comment as it was being developed. The strategy would be considered for approval at the next meeting on 14 December. ▪ Following the Partnership meeting, there was a deep dive workshop on the children and young people with wider stakeholders and the outputs of the workshop are being used to feed into the strategy development.
Decisions for approval by the Board
▪ There are none

Primary Care Commissioning & Assurance Committee in Public 27-09-2022
Update to Board on key points
The Committee: ▪ approved terms of reference for Primary Care Delivery Group and updates to PCC&AC; noted that both would continue to be developed during 2022-23 ▪ noted progress against the Primary Care Workforce Programme strategic workstreams ▪ endorsed progress on North Bedford Primary Care Hub project; outcome and response rate to the Patient Engagement exercise and actions being taken to mitigate concerns of the population in relation to availability and cost of parking on site ▪ noted process, criteria and timeline agreed by the Estates Working Group for prioritising primary care estates schemes ▪ endorsed the proposed BLMK Fuller Programme to implement national recommendations; supported the approach for the principle of subsidiarity ▪ noted primary care access oversight group update and next steps. Requested focus on digital developments in terms of telephony and wider digital offer as future agenda item for the Primary Care Delivery Group ▪ accepted that risks relating to the primary care directorate and digital transformation programme were identified and managed by the relevant teams; all risks continue to be logged and monitored in the 4Risk system ▪ noted the July 2022 delegated primary care financial position ▪ reviewed the draft annual business cycle.
Decisions for approval by the Board
▪ There are none

Quality & Performance Committee 2-09-2022
Update to Board on key points
▪ Patient Safety Incident Response Framework, was published nationally in August 2022. It will replace the Serious Incident Framework and gives 12 months for implementation. The Framework represents a cultural change and approach to patient safety responsibility, response and accountability. ▪ Planning is underway for delivering effective management of Ophthalmology waiting lists via the Elective Recovery Board. Thought needs to be given to how the system is mitigating Urgent Care pressures in response to the demand the system is encountering.

- workforce is recognised high-risk area, i.e., capacity in health, social care, Urgent Care and Emergency Care; thought needs to be given regarding how to share information across all relevant committees. Determine next steps in developing longer-term practice and use of committee, views and objectives
- Nationally, mental health services are seeing up to 50% increase in demand for access to more intensive mental health support sooner. There are significant cost pressures across the system and a lack of clarity on funding streams beyond 2023/24. There is concern on delivering a balanced CAMHS plan in light of a £1.8 million gap in funding resources.
- Committee was requested to note the challenges with completing Initial Health Assessments for out of county placements, the impact on service provision and capacity and mitigations needed to improve service delivery
- The maternity system is currently under significant scrutiny, nationally and regionally (Ockendon National Review Report). There are significant workforce challenges, the national mandated care model across both hospital trusts is under pressure with recruiting; maintaining training standards is also impacted by workforce issues and delivery of a digital workforce strategy to drive improvement is presenting as a barrier for much of the work underway.
- Lakeside Hospital Closure - BLMK ICB, as the host commissioner worked with over 20 other commissioners across the country to oversee the successful transfer of 29 patients to alternative placements.
- The Committee considered and supported the Gamete Storage Policy.

Decisions for approval by the Board

- There are none

Working with People & Communities 7-10-2022

Update to Board on key points

- The Working WWPAC committee met on 7 October 2022. The meeting was chaired by Manjeet Gill, the new committee chair.
- The revised Terms of Reference which were approved by the Board on 30 September 2022 were noted. The committee agreed that they would be kept under review due to queries regarding membership and voting rights.
- There was a discussion around the best way to bring the stories of residents into Board and committee members. The Associate Director for Communications and Engagement agreed to work with Healthwatch and partners to build a framework and develop a forward plan for resident stories.
- The committee discussed and provided feedback on the Working with People and Communities Strategy and Implementation Plan, noting the essential role that ward councillors and Foundation Trust members could play. It was agreed that the strategy and implementation plan would be updated to reflect the committee's feedback and published in an accessible way to the public.
- The committee provided feedback on the draft BLMK ICB and VCSE Memorandum of Understanding (MoU) which is being developed. The feedback will be considered and incorporated as the MoU is further developed.
- There was a discussion regarding the role of the committee and ensuring it was aligned to the ICB, and that appropriate system partners were invited to future meetings if the discussions were regarding ICS activity rather than ICB.
- The committee noted the work being undertaken on the Denny Review which focuses on gaining an understanding of which communities experience the greatest inequalities in BLMK.
- The committee noted and supported the contents of the winter communications plan for the Bedfordshire, Luton and Milton Keynes Health and Care Partnership, the plan encompasses activity that will be undertaken by all system partners.
- Clarification was provided that the statutory requirement to engage and consult on health services had transferred from BLMK CCG to the ICB. The committee were provided with an overview of the potential statutory consultation/engagement work which is scheduled for 2022/23. The committee noted and supported the plan.

• The committee agreed that the newly formed Engagement collaborative should sit as a community of practice, rather than a sub-group or sub-committee of the committee.
Decisions for approval by the Board
▪ There are none

Attachments – draft minutes, approved by Chair:

a) Audit & Risk Assurance Committee – 2 September 2022
b) Finance & Investment Committee – 17 October 2022
c) Health & Care Partnership – 21 September 2022 –
d) Health & Care Senate – 6 October 2022
e) Primary Care Commissioning & Assurance Committee – 27 September 2022
f) Quality & Performance Committee – 2 September 2022
g) Working with People & Communities Committee – 7 October 2022

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 2 September 2022

Time: 14.00 – 15.15

Venue: MS Teams

Minutes of the: Audit & Risk Assurance Committee – (Part 2 - System Risk Management)

Members:		
Andrew Blakeman (Chair)	Non-Executive Member	ABl
Alison Borrett	Non-Executive Member	ABo
Shirley Pointer	Non-Executive Member	SP

In attendance:		
Kim Atkin	Committee Governance and Compliance Officer	KA
Ola Hill	Deputy Head of Organisational Resilience	OH
Stephen Makin	Deputy Chief Finance Officer	SM
Kwame Mensa-Bonsu	Trust Secretary, Milton Keynes University Hospital NHS Foundation Trust	KM-B
David Stout	Development Director, Milton Keynes Health & Care Partnership	DS
Dean Westcott	Chief Finance Officer	DW
Sarah Whiteman	Chief Medical Director / Caldicott Guardian	SW
Maria Wogan	Chief of System Assurance and Corporate Services	MW

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting and advised that the main agenda item for this meeting is a workshop to discuss how system risk is managed. Some additional attendees from the place have been invited to join the workshop. Everyone present introduced themselves and apologies from members were received and noted as above. The meeting was confirmed to be quorate.	
2.	**Relevant Persons Disclosure of Interests** 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: ▪ Confirm that all offers of Gifts and Hospitality received in the last 28 days have been registered with the Governance & Compliance T ▪ Declare any relevant interests relating to matters on the Agenda. There were none declared.	
3.	**How do we want to run the System Strategic Risk Committee** **Background** A paper was circulated prior to the meeting which highlighted the main areas for discussion: • Understanding of the system risks • Our risk appetite • The barriers to resolving risks; and • Mitigation and action plans that are in place. The aim is to work with all partners to develop the system risk management approach that will be implemented as a Board. The policy for System Risk Management was agreed at the first meeting of the Board of the Integrated Care Board (ICB). All of the risks that remained on the Clinical Commissioning Group (CCG) Board Assurance Framework (BAF) at the time of cessation, were reviewed in July by the System Oversight & Assurance Group (SOAG) and decisions and recommendations made as to which should transfer to the ICB. The Chief Executive requested to add some further risks, and the draft BAF was taken to the meeting of the Board of the ICB on 29 July 2022, where it was reviewed and agreed for a couple of additional risks to be added. Further work is needed to the detail and to look at risk scores, mitigating actions and controls. We have set up a 'community of practice with leads from across the NHS organisations to talk about risk management, how their BAFs/Risk Registers could link across to the System Risk Register, the escalation process and how that might work. There will be a further report to the Board of the ICB on 30 September 2022. The next SOAG meeting will have a bigger focus on risk and how they are managed between us, and a Board Development Session on 4 November 2022 will also focus on system risk management. **Key points from discussion** The main criteria for system risks are: <u>Strategic risk</u> - relating to risks that are longer-term, over a period of possibly three to five year period (but to be agreed), and that impact multiple partners across the ICB and where there needs to be some form of aggregated risk assessment. For these risks, there needs to be a lead partner and other organisations will act as enablers.	

	Interaction risks - which affect the way we do business within the system, for example, delays in accessing urgent and emergency care (UEC), which will affect many partners in different ways and therefore present a risk to the entire system. An escalation process needs to be identified from partners or place to this forum and onto the BAF. DS queried whether the "system" in this context was NHS only or wider, referring in particular to the concern within local authorities that there is insufficient funding for social housing. This point was taken on board and it was acknowledged that we are currently looking at the risks from an NHS perspective, but further work is needed on determining the interaction risks that affect the health and social care of our population. MW – The role of the ICB is to deliver the Integrated Care Strategy for Bedfordshire, Luton & Milton Keynes and strategic risks are those that could prevent delivery of that strategy. SP highlighted that we are unlikely to make an impact on some of the high-rated risks, such as workforce, where there would need to be a new national approach to funding and modelling for there to be any real change. Whilst we will continue to do all that we can to ensure that resources are used efficiently and that there is no duplication, we need to understand that this is not under our control. We should focus on risks we can control. As a system, we will collectively seek to mitigate risks that have been escalated but, when a risk remains above the system risk appetite, such as workforce, then the ICB would work with the region and national teams to address the wider issue. SP also felt that, as an ICB, we have a responsibility to voice upwards to the national agenda and use our understanding of risk to frame and influence the discussion. DW – The risks relating to care, including workforce and domiciliary care works, would probably be the ones that would be escalated to the system BAF. There would also need to be line of sight with providers who are fundamental to our systems but who do not operate within the system boundary, such as mental health. How would those risks be captured? ABI – Our risk appetite is the level of risk that we can tolerate, and anything above that is a residual risk. Those risks that, despite doing all that we can to mitigate, remain above the target level would be escalated up to organisations. The Board development session in November will help us to frame our risk appetite. There was a discussion as to how best to engage with partners: SP – proposed that the Bedfordshire Care Alliance (BCA) and Milton Keynes (MK) Deal have an overview of strategic risks for their areas and takes the decision of which to escalate to a system level, where common schemes across the system are identified. The ICB BAF would then be a small number of big ticket items, while the smaller items, with less interaction, would remain on the subsidiary risk registers.	

KM-B – In a previous Trust, where there was one council and one place, risk came down from place, not from the hospital, it included both NHS and local authority risks, such as housing, and it was articulated as to how it impacted on healthcare and the health and wellbeing of the population.

DW – keep it simple. Not all places currently have a risk register or infrastructure, dependent on the stage of their development. It is important not to be seen to duplicate activities that are already taken place in the system.

DW considered the benefits of synergy – the "ability" to message upwards and the fact that all organisations will be on the same page and aware of wider issues in the system, useful when attending meetings with other organisations, both within and outside our system.

There was concern that some organisations may feel they are already "interfered" with by the region and Care Quality Commission (CQC) and feel that there is duplication of intervention. The ICB would need to have a sympathetic understanding of the organisations' position and build relationships with organisations so that we are not seen as authoritarian.

ABo – We need also to remember the "here and now", such as fuel poverty, which could stop us looking to the 3-5 year risks. Communication of the key risks is vital, not just to senior people, but others in the organisation who need to understand them.

It was agreed that to keep the high level risk summary to a single page – more impactful and, if there are too many, they probably are not "key".

ABl –proposed process:

- We obtain all of the available risks registers and review them;
- We consider which can be aggregated into less, but larger and "interaction", risks and summarise them into a system BAF;
- We decide what action to take in relation to each of these risks, of the following:
    - Work together locally across the providers and the system to solve;
    - Support providers to work together to solve the problem (the ICB takes a lead in solving the issue)
    - Decide that the risk is beyond our control and escalate to NHS England, depending on the type of risk.
- Effective communication of our top risks which we can all use e.g., one slide that has no more than 100 words.

It was felt that the ICB BAF would look at high level actions or mitigations, while the organisations themselves would manage the granular detail.

It was agreed that core attendance for the committee would be from the ICB with providers invited where a particular discussion will be useful and interesting for them. Optional attendees would not be invited to all meetings, but there would be a rotation of attendees from different organisations, so that there could be a more focussed discussion on matters relevant to that area or organisation. Could consider inviting Audit Committee Chairs.

Action: MW to draft a clear definition for 'system risk'.

	Action: ABl, MW and OH to discuss how to manage rotation of optional attendees.	
4.	**Communications from the Meeting** There was insufficient time for this item during the meeting. However, following the meeting, the Chair agreed the following list for wider communication: • The Audit and Risk Assurance Committee held a constructive workshop on Friday 2 September on the process for managing system risk in BLMK. • We set out a process for identifying, assessing and monitoring risks across the system, building on the work already done by the BLMK Clinical Commissioning Group in its handover to the ICB, the System Oversight and Assurance Group (which comprises the Chief Executives from NHS Trusts, Local Authorities and the ICB) and others. • We discussed how to engage people across the system without having unwieldy meetings and asking for a lot of time from already busy people. • Mindful of the need to focus on the key system risks, we set an aspiration to keep our highest level of risk summary to a single page, on the grounds that we ought to be able to recall our key risks from memory, and if there are so many that we can't, they probably aren't really "key". • Given the work already done by system partners, and the need not to duplicate efforts, we set a process to review the risk registers already held across the system to identify the key risks and the work already being done to manage them, without requiring any new inputs or reports as an initial step. • The ICB has a role to play in co-ordinating the management of system risks, and to encourage action at a system level (with system partners) where joined-up action is necessary and effective. • We also have a role to identify those risks that cannot be adequately mitigated within the system and which need to be escalated to a regional or national level. • Part of the goal of our system risk work is to build alignment on what are our top risks and what we need to do – that will allow us to communicate externally more powerfully because our message will be clear and consistent.	
5.	**Review of Meeting Effectiveness** This item was not discussed.	
6.	**Annual Cycle of Business (next meeting agenda items)** This item was not discussed.	
7.	**Any Other Business** There was no further business.	
8.	**Date and Time of Next Meeting** • 2 December 2022 • Teams Meeting • Time TBC Deadline for papers will be: • 22 November 2022 The meeting closed at 15:15	

Approval of Minutes:		
Name	Role	Date
Andrew Blakeman	Non-executive Member and Chair of the Audit & Risk Assurance Committee.	18.10.2022

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: Monday, 17 October 2022

Time: 13:00 – 15:00

Venue: MS Teams

Minutes of the: Finance & Investment Committee

Members:		
Name	**Role**	**Initials**
Rima Makarem	Chair	RM
Anne Brierley	Chief Transformation Officer	AB
Dean Westcott	Chief Finance Officer	DW
Kathryn Moody	Director of Contracting	KM
Manjeet Gill	Non-Executive Member	MG
Martha Roberts	Chief People Officer	MR
Nicky Poulain	Chief Primary Care Officer	NP
Sarah Stanley	Chief Nursing Director	SS
Sarah Whiteman	Chief Medical Director	SW
Nikki Barnes	Head of System & CCG Estates	NB
Stephen Makin	Director of System Finance/Deputy Chief Finance Officer	SM
In attendance:		
Name	**Role**	**Initials**
Beverley Husbands	Secretariat	
Apologies:		
Name	**Role**	**Initials**
Alison Borrett	Non-Executive Member	
Maria Wogan	Chief of System Assurance & Corporate Services	
Michelle Evans-Riches	Integrated Care System Programme Manager	
Richard Alsop	Director, Commissioning, Contracting & Transformation	
Shirley Pointer	Non-Executive Member	

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The chair welcomed everyone to the meeting. Apologies were received and noted as above. The meeting was confirmed as quorate	
2.	**Relevant Persons Disclosure of Interests** Members were asked to review the Register of Interests [Appendix A] and confirm their entry was accurate and up-to-date, and to confirm that all offers of Gifts and hospitality received in the last 28 days had been registered with the Governance and Compliance Team. Members were also asked to declare any relevant interests relating to matters on the agenda. None were declared.	
3.	**Approval of Minutes from Friday 29th July 2022 and Matters Arising** The minutes were approved as an accurate recording; there were no matters arising	
4.	**Finance Report Part A and Part B**	

No.	Agenda Item	Action
	4.1 DW gave highlights from the Board Report. A break-even position is forecast for the year. Noted, inflation, winter demand and capacity issues, operational costs and prescribing costs present potential for significant financial pressures. 4.2 Noted there is some slippage in payment performance, due in part to invoices being held up in authoriser workflows. 4.3 RM – query – 3.4 non-recurrent programme allocations – are there mitigations in place if there is no further funding available? DW explained there are a number of initiatives coming up, running for 1, 2 or 3 years that may have allocated funding. They are included in the medium-term financial plan, based on a 5 year system outlook, and will be closely tracked, with efficiencies prioritised where necessary. 4.4 RM – query – New Ophthalmology provider is identified as a cost to the ICB, how is there a cost with no contract in place? KM explained a decision was made, at national level, to commission Spa Medica to support Ophthalmology recovery; although there is no specific NHS contract in place, they are covered by an implicit contract to provide services. RM noted contracts in place are not equitable across the system due to various exceptions and queried the controls and governance in place. KM explained block contracts attract higher risks which need to be considered and balanced almost on an individual basis, there is also less control and additional risks where BLMK is not the lead commissioner. Contractual conversations continue as a system, regionally and nationally, with a view to drawing greater alignment across the system, where appropriate. 4.5 It is likely that the cap on agency rates of £27 million will be breached due to demand and capacity and workforce management, (i.e., tackling elective backlog, staff sickness/absence, vacancy rate). Region has been alerted to the likelihood of a breach. RM queried whether any further consideration was given to one shared staffing bank, as this will mitigate higher agency charges. MR explained there is difficulty with Milton Keynes engagement, a regional piece of work is underway for medics, and there is engagement with a reservist scheme. DW advised a shared banking agency is one of 6 high-level transformation priority schemes to be discussed further with MR and AB. 4.6 RM – query – where are we with recognising inter-organisational system efficiencies versus intra-organisation, also what kind of engagement is there with frontline staff, who are often best-placed to identify efficiencies on an inter or intra-organisational level? DW advised there is a programme of work underway which will be progressed with AB. The value of frontline staff input was acknowledged.	
5.	**Finance Risk Register** 5.1 DW – significant risks identified with management system running costs; in-year vacancies leave BLMK in a fairly good position, however, should all positions be filled next year there is likely to be a cost pressure of approx. £1 million; the executive team are sighted and focused on this risk. 5.2 MG – is there a reducing risk with Covid infections and [1]IPC? – DW responded although there has been a recent increase, in general, numbers have plateaued. There is a risk with Covid funding, which was cut by 57% this year and forecast to be cut further next year if infection rates remain stable; this is to be discussed further with system finance directors. SS noted if there are significant increases in infection rates/acuity more extreme IPC measures will be brought in, which will have a direct impact on costs and introduce delays in pathways. MR – communications are out to promote vaccinations for staff and local community, noted that most unions	

[1] Infection Prevention & Control

No.	Agenda Item	Action
	are out to ballot for strike action which will have an impact on workforce management and emergency preparedness. 5.3 AB – where are risks around the supply chain resilience captured/reflected, e.g., prescriptions with no cheaper option. KM - this should be part of contracting and procurement market management and is a work in progress.	
6.	**Update on Medium Term Financial Plan and draft position for 22/23** 6.1 DW - With the recent change in government, it is looking unlikely that funding expected in October will be allocated. Further guidance is expected in December with draft system plans submitted January / February 2023. Work is underway for medium-term financial planning. A dynamic baseline financial model was developed with key system partners, and with the acknowledgement further analysis is needed, there is confidence that there are no significant variances to previous forecasts. Once allocations are advised, a more structured, detailed financial plan will be generated.	
7.	**Transformation and Efficiencies Update** Deferred to next meeting	
8.	**Procurement and Contracting Update** 8.1 KM - With a system wide view, we have been exploring how contracting can be redeveloped to drive change and deliver transformation in the ICS rather than being used as a transactional tool also considering alternative ways of reporting progress, i.e., sustainable outcomes versus activity data, [2]PBR versus block contracts, etc. This is a priority area of work in progress. 8.2 RM - Preferred reporting style would be for shorter papers that focus on difficult areas that will benefit from strategic consideration / response / support of this committee. **Action: Provide a view on what contracting across the system will look like going forward.** 8.3 MG – there is an opportunity to look at what market development could look like for BLMK. Rather than outsourcing to high-cost out of area placements and/or trying to compete with the commercial market, consider the feasibility of creating local resources that could generate income. 8.4 AB – it is acknowledged, as a new organisation moving in a different direction, ongoing collaborative development is still needed at place and system-wide through transformation and efficiencies initiatives for robust contractual governance, levers, standards, trajectories, etc.	KM
9.	**Capital Activities Plan** 9.1 NB – Paper 1 -There is a £1.6 million allocation for Primary Care capital that can be used for Primary Care IT and Estates and Corporate IT and Estates. Noted the Primary Care Estates Prioritisation Process concludes in November. NHSE guidance for supporting General Practice Primary Care Networks through winter planning was published and gives additional opportunities to bid for further capital funding and non-recurrent revenue; a bid will be ready for submission on 9th November. 9.2 A bid was submitted to the Healthier Futures Action Fund to bring in consultants to provide energy efficiency assessments for Primary Care Estates; it was unsuccessful but discussions for alternative opportunities continue in this important area. 9.3 RM – Prior to any endorsement or agreement it would be useful to have sight of the framework that governs decision-making on how allocated funds are prioritised now, and in the future, especially in light of PCN development, hubs, etc. DW clarified the paper is brought to this committee to note at this point, endorsement for Primary Care projects will go to the Primary Care Committee.	

[2] Payment By Results

No.	Agenda Item	Action
	9.4 Paper 2 - A prioritisation process is underway for the BLMK Hub programme; it is resource intensive which has an impact on capacity, affordability, workforce. Wider market conditions also have an impact on other capital schemes. A Capital & Estates Oversight Group has been set up which includes system financial and estates directors; updates will be brought to the next committee. 9.5 RM cautioned against co-location rather than integration, i.e., service providers working together rather than just using the same space. NP advised The Fuller Stocktake Report principles underpin ongoing development of integrated health and care systems. 9.6 Paper 3 – Business Case for North Bedford Hub was submitted In September with agreement to submit a further addendum in November covering the final contract price, multi-party agreement and final lease agreement 9.7 There is a scheme for DeParys Medical Centre, to be relocated to the Bedford Health Village site, DeParys Medical Centre is our biggest GP practice with a list size of 40,000 spread across four premises. Their patient-facing services will be co-located with a range of community and mental health services, promoting an integrated, streamlined and more efficient health and care service provision and a greater focus on proactive and preventative care. 9.8 The business case is recommending refurbishment of 2 assets at a cost of just over £7 million. Noted cost benefits will be in the form of wider societal benefits and efficiency savings rather than cash release and does create a cost pressure of approximately £295,000 per annum. There is a system commitment to manage cost pressures through in-year savings. There is a regional review currently underway, with an anticipated national review and approval by December 2022 and a new facility due to be up and running by Autumn 2023. MK queried arrangements for parking facilities in the business case and governance behind ICB versus place-based decisions. 9.9 NB – transportation consultants were brought in to develop a transportation strategy for this site. There is access to 257 parking spaces as well as public transport options and free local parking spaces presenting ample capacity in the area and onsite. Measures will be taken to ensure equitable access to parking facilities for staff and patients. A leaflet will be provided for all DeParys patients advising of all transportation/parking options. A review of this arrangement is planned within six months of the hub becoming operational. It was highlighted that governance arrangements would benefit from further review.	
10.	**Digital Update** Update provided at the last Integrated Care Board	
	Governance	
11.	Communications from the meeting	
12.	Review of meeting effectiveness Upon review, it is noted that that meeting papers need to be more focused, at times less detailed, to help the committee hone in on the key issues	
13.	Annual Cycle of Business To be added to next agenda • Transformation and Efficiencies update – Richard Alsop • Update from the Capital & Estates Oversight Group – Nikki Barnes	
	Closing Items	
14.	**Any other business** 14.1 Community Diagnostic Centres (CDC) - SM explained this item is brought to the committee to provide awareness of CDC Programme; there will be a business case that needs to come to this committee 14.2 MR gave an overview of the BLMK Diagnostics Programme for Community Diagnostic Centres i.e., diagnostic centres in the community, outside of emergency escalation and acute diagnostics. BLMK Model proposes hub	

No.	Agenda Item	Action
	and spoke models, 2 spokes in Milton Keynes, 1 hub in Bedford, sighted in the Bedford Health Village. Luton spoke / hub has yet to be scoped. 14.3 RM expressed grave concerns that the proposals appear to be driven by the acute hospitals and at first sight present inequalities across the BLMK system. 14.4 MR acknowledged the drive from acutes and significant challenges for this programme. Drafts are being updated for both Milton Keynes and Bedfordshire Hospitals with a plan to combine them into an overarching paper, which will include business cases, figures for current/future capital and revenue, next steps, future planning and development, etc. There are also ongoing conversations with Luton & Dunstable Hospital regarding re-development of an endoscopy unit at their site, as well as considering alternative locations, on or off site, for Luton CDCs. A paper will be presented to this committee and the Board. 14.5 AB – it is recognised at the time of the request to deliver CDCs, 2½ years ago, the focus was on quick capital investment around big technology. It is acknowledged there were significant omissions in the original main minimum programme requirements and planning, due to time constraints for submission. **Action: Conduct a stocktake of the CDC programme to determine which parts of the programme will proceed, with further review of the bid** 14.6 SS expressed concerns that decisions may have been made by a small group of clinicians from acute trusts for the short term rather than being properly risk-assessed with medium and long-term planning, over 5 – 10 years for the BLMK system. Recognising presenting inequalities and significant challenges, SS & RM queried whether there is any scope to pause and reconsider alternative solutions/prepare a Plan B. 14.7 RM queried whether there is there any scope for the funding adapted to ensure the development of the CDCs is fit for purpose with greater equality across the whole of the BLMK Health and Care System. 14.8 DW – it would be beneficial to gain clarity around timescales, in light of points and concerns raised; further discussions are needed regarding revenue implications if changes are made, which will have an impact on how the agreed capital is dispersed.	AB / DW / MR
15.	**Date of next meeting** **Date:** Friday, 09 December 2022 **Time:** 13:00 – 16:00 **Via:** MS Teams **Deadline for papers: Noon 29 November 2022**	

Approval of Minutes:		
Name	**Role**	**Date**
Finance and Investment Committee	Final Approval	Click or tap to enter a date.
Rima Makarem	Chair	02/11/2022

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 21-09-2022

Time: 17.10

Venue: Council Chamber, Central Bedfordshire Council

Minutes of the: Health and Care Partnership

Members:			
Surname	Forename	Title	Initials
Stock	Tracey	Chair	TS
Bahray	Baz	PCN Clinical Director Luton	BB
Cartwright	Sally	Director of Public Health, Luton	SC
Cox	Felicity	CEO BLMK ICB	FC
Davis	Alison	Chair Milton Keynes Hospital	AD
Elford	Mary	Chair Cambridgeshire Community Services	ME
Head	Vicky	Director of Public Health Bedford Borough, Central Bedfordshire and Milton Keynes	VH
Hussain	Javed	Councillor, Luton Borough Council	JH
Jackson	Louise	Chair of the Health and Wellbeing Board, Bedford Borough Council	LJ
Keech	Tracy	Healthwatch Milton Keynes, Deputy CEO	TC
Kocen	Jane	PCN Clinical Director Bedford	JK
Makarem	Rima	Chair BLMK ICB	RM
Malik	Khtija	Public Health and Commissioning Luton Council Portfolio Holder	KM
Marland	Peter	Leader, Milton Keynes Council	PM
Mehta	Sonal	BLMK VCSE Lead	SM
Ogley	Julie	Director of Social Care, Health and Housing, Central Bedfordshire Council	JO
Rammohan	Navaneetha	PCN Clinical Director, Milton Keynes	NR
Simmons	Hazel	Leader, Luton Borough Council	HS
Sisodia	Mrunal	NED, East of England Ambulance Trust	MS
Taylor	Eileen	Acting Chair, East London Foundation Trust	ET
Terry	Helen	CEO, Healthwatch Bedford Borough	HT
Walker	Kate	Director of Adult Services, Bedford Borough Council	KW

In attendance:			
Surname	Forename	Title	Initials
Bigland	Chris	Bedfordshire Fire Service	CB
Roberts	Martha	Chief People Officer, BLMK ICB	MR
Scanes	Paul	Buckinghamshire Fire Service	PS
Tovey	Hilary	Director of Strategy and Planning, BLMK ICB	HT
Wogan	Maria	Chief of System Assurance and Corporate Services	MW
Evans-Riches	Michelle	Programme Manager ICS Transition, BLMK ICB	ME-R

Apologies from members:			
Surname	Forename	Title	Initials
Bradburn	Robin	Councillor, Milton Keynes Council	RB
De-Carteret	Emma	Director of Corporate Affairs and Performance, East of England Ambulance	ED
Griffiths	Dorothy	Chair CNWL	DG
Linnett	Simon	Chair Bedfordshire Hospitals	SL
MacPherson	Angela	Leader, Buckinghamshire County Council	AM
Nicholson	Lucy	Healthwatch Luton	LN

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting. Apologies were received and noted as above. The meeting was confirmed as quorate.	
2.	**Relevant Persons Disclosure of Interests** Members were asked to declare any relevant interests relating to matters on the agenda and there were none declared.	
3.	**Approval of Minutes and Matters Arising** The minutes of the meeting held on 4 July 2022 were approved.	
4.	**Review of Action Tracker** The action tracker was reviewed, and the following actions were approved to be closed: a. Action 1 Health and Care Partnership Terms of Reference b. Action 3 Integrated Care Strategy It was noted that action 2 Health and Care Partnership Terms of Reference remains open, as it relates to paragraph 8.1 whereby authority is delegated by the Integrated Care Board and this has not occurred to date.	
5	**Appointment of Health and Care Partnership Deputy Chair** The Health and Care Partnership Agenda Setting group has recommended that Rima Makarem, the Integrated Care Board Chair, be appointed as the Deputy Chair of the Health and Care Partnership for a period of two years. It was moved, duly seconded and **Agreed: That Rima Makarem be appointed as the Deputy Chair of the Health and Care Partnership for a period of two years.**	
6	**Draft Integrated care strategy update**	

	The report provided an update on the development of the Integrated Care Strategy and proposed an approach of publishing a high-level strategy in December with a series of deep dives to help inform a more detailed strategy in 2023. The strategy will inform the Joint Forward Plan which the ICB is responsible for developing and is required to be published in March 2023. Engagement on the strategy will be combined with the Joint Forward Plan to help develop a line of sight between the actions being taken and the ambitions detailed in the strategy. National guidance has been published which supports the proposed approach The strategy will formalise the ambition of the system against the ICS priorities and enablers, using population health information and building from Place plans and Health and Wellbeing Strategies. The model of deep dives on specific areas is being tested in a Children and Young people workshop taking place immediately following this meeting. An Inequalities deep dive session planned for 5 October; all Health and Care Partnership members have been invited. Work is also underway with the mental health programme following a recent deep dive to agree how this will be incorporated into the system strategy. Health and Care Partnership members will be invited to feed into this work. Health and Care Partnership members requested that draft iterations of the Integrated Care Strategy are shared with them for comment as it is developed with tracked changes to enable ease of identification of any amendments made. The strategy needs to reflect what is happening at Place. The Agenda Setting Group will develop a timeline for communication on the strategy with members. The strategy needs to be flexible enough to ensure it is still relevant given changing circumstances, but specific enough to identify the priorities and collaborative change required. It was emphasised that the strategy sets the ambition, but it was the delivery that is important to our residents and this needed to be implemented at pace, recognising that Places are at different stages. The ICB Board is working with Places to decide upon delegation of responsibility and the associated resources. **Agreed that the following be approved:** **1.The approach to deliver a light touch strategy in December 2022 with a focus on specific priority areas** **2. To establish a series of 'deep dive' sessions over 2022/23 and 2023/24 and identify what specific areas would you like to see included within these and agree that the Health and Care Partnership Agenda Setting Group should be responsible for agreeing the programme of deep dive sessions.**	**ACTION 4 HT**
7	**Questions from the Public** None were received.	
8	**Communications from the meeting** Key communications from the meeting are:	

	• The Integrated Care Strategy will set the strategic overarching ambition for Bedfordshire Luton and Milton Keynes. • There will be a series of deep dives, with the first focusing on children and young people that will help inform the strategy and the plan for subsequent sessions will be developed for the next year. • Delivery of the strategic ambition will be detailed in the Joint Forward Plan specifying how, when and by whom, actions will be taken. • The emphasis was on collaborative working, with partners working to a common goal. • Engagement with our residents and staff will be integral to the process of developing and implementing the strategy.	
9	**Health and Care Partnership Forward plan** The next meeting would consider the draft high level Integrated Care Strategy and members were asked to inform the Partnership Secretariat if there were any other items for the agenda. **Noted**	
10	**Any Other Business** Members will be invited to provide feedback on the format of the meeting followed by the workshop. A glossary of acronyms will be circulated to members.	
11	**Date and time of next meeting** • 14 December 2022 Venue to be confirmed	

The meeting ended at 17.47

Approval of Draft Minutes by Chair only:		
Name	**Role**	**Date**
Tracey Stock	Chair	29-10-2022

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: Thursday 06 October 2022

Time: 1.00 – 3.00pm

Venue: Microsoft Teams

Minutes of the: Health and Care Senate

Members:		
Name	**Organisation**	**Initial**
Angharad Ruttley	ELFT	AR
Bola Soyombo	MK LDC	BS
Claire McKenna	MH	CMc
Emma Jones	CNWL	EJ
Gerald Zeidman	LPC	GZ
Helen Chadwick	MKUH	HC
Helen Glyn-Davies	AHP Council	HGD
Ian Reckless	MKUH	IR
Kate Howard	CCS	KH
Kathy Nelson	BLMK ICB	KN
Nina Pearson	Primary Care	NP
Nicky Williams	LMC	NW
Paul Tisi	BHFT	PT
Patricia Coker (Julie Ogley deputy)	Central Bedfordshire Council	PC
Pritesh Bodalia	BHFT	PB
Reginald Akaruese (Anshu Rayan deputy)	CNWL	RA
Rick Watson	BHFT	RW
Sally Cartwright	Luton Council	SC
Sarah Whiteman **(Meeting Chair)**	BLMK ICB	SW
Vicky Head	Public Health	VH

In attendance:		
Name	**Organisation**	**Initial**
Christina Cannell (Minutes)	BLMK ICB	CC
Sian Pither – Item 5	BLMK ICB	SP
Linus Onah – Item 5	BLMK ICB/Primary Care	LO
Robert Sherwin – Joined for AOB	NHSE – Specialist Commissioning	RS

Apologies:		
Name	**Organisation**	**Initial**
Adam Staten	MK GP Federation	AS
Anshu Rayan	CNWL	AR

Helen Willets	CNWL	HW
Janet Thornley	Nurse Strategic Lead	JT
Julie Ogley	CBC	JO
Kate Walker	BBC	KW
Liz Lees	BHFT	LL
Sanhita Chakrabarti	BLMK ICB	SC
Suraiya Chandratillake	ELFT	SCh
Tayo Kufeji	Primary Care/BLMK ICB	TKU
Victoria Collins	Milton Keynes Council	VC
Yolanda Bunga	CCS	YB

<table>
<tr><th>No.</th><th>Agenda Item</th><th>Action</th></tr>
<tr><td>1.</td><td>Welcome, Introductions and Apologies:

The Chair welcomed members to the second meeting of the Health and Care Senate. Apologies were received and noted as above and the meeting was confirmed as quorate.</td><td></td></tr>
<tr><td>2.</td><td>Conflict of Interest Management & Standards of Business Conduct Policy:

Conflicts of Interest

Members were asked to declare any relevant interests relating to matters on the agenda.

IR – Non Executive Director of the Royal Orthopaedic Hospital in Birmingham. No direct CoI for agenda item 5.

Gifts and Hospitality

Members were asked to confirm if they have received any gifts or hospitality in the last 28 days in the capacity of working for the ICB, not their current NHS roles.

No declarations were noted.</td><td></td></tr>
<tr><td>3.</td><td>Approval of Minutes and Matters Arising

The minutes from the meeting held on 14 July 2022 were agreed as an accurate record.

Matters Arising

No items were noted.</td><td></td></tr>
<tr><td>4.</td><td>Review of Action Log

The action log from the 14.07.022 meeting was reviewed and noted as below:

<table>
<tr><th>Item Title</th><th>Action</th><th>Update</th></tr>
<tr><td>Terms Of Reference</td><td>Membership: Widen the membership of the Senate to include the LMC, Local Pharmacy, Optometry and Dental Committees.</td><td>LMC, Local Pharmacy and Dental Committees invited to join the membership of the group. Optometry Committee to be invited once contact details confirmed.</td></tr>
<tr><td>Terms Of Reference</td><td>Vice Chair role: To be updated to reflect the agreed change of ICB Chief Nurse to the Director of Public Health for Bedford Borough, Central Bedfordshire and Milton Keynes Councils.</td><td>Action completed and closed.</td></tr>
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Percutaneous Coronary Intervention (PCI) Strategy	Feed back to the ICB ahead of the ICB Board meeting on the 29.07.22	Action completed and closed.	

5. **Musculoskeletal Services (MSK) Health Needs Assessment (HNA)**

Context:

A review of MSK services is currently underway as the 4 current contracts are due to end on the 31st March 2024 with a new model of care to begin from the 1st April 2024.

To inform the redesign work patients and clinicians have been surveyed from Primary, Community and Secondary Care across the BLMK patch and the local Public Health team have produced a health Needs Assessment (HNA) specifically for MSK based on the following main areas:

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

Following the HNA an action plan has been developed which focuses on prevention, reducing demand, streaming pathways, rehabilitation, pain management, links to mental health.

Discussions/Feedback:

- RW highlighted that the work undertaken clearly shows the engagement with stakeholders and service. The potential risk to contract extension was raised given the expected difficult winter to come. SP said that procurement is due to start in April 2023. There is a lot of work to do around baselining etc but all are working to a timeline to ensure this is delivered.

- SW raised the traditional re-procurement model and if there is scope to think differently about the approach to ensure local needs are met.

- GZ raised the timescale for re-procurement and highlighted that community pharmacy have a huge role to play in reducing falls etc which need to be linked into the service. LO said that a separate piece of working is taking place around falls but there is a clear link and will be a SPOC where community pharmacists can refer patients into the service directly.

- NP raised the service provision in Luton is not adequate therefore it is key this is re-procured asap. If asked to suspend non routine work this needs to continue as risk around it is so high, along with ENT.
- LO said the team are also looking at social prescribers to help patients who need extra needs navigate the system.

- KN raised the population health data – can we show what the population needs and needs to be done within X timeframe to articulate what this would achieve in terms of benefits.
- Digital technologies was raised specifically those that could also support self-care management etc.
- BS raised that having integrated dental pathways would be useful to help signpost patients, there are also a group of patients that need the service and haven't contacted their Dr but dentists also know what medication patients are taking or supposed to be taking and are not therefore having a clear link to refer patients into the service would be valuable.

	• RW raised that they key priorities need to be delivered on and community prevention is key. • VH said that from a public health perspective, it has been positive re the joint HNAs that's been produced. Physical activity is an area that more can be done in terms of prevention. **Recommendation from the Health and Care Senate:** **The HASC noted the HNA, specifically the role of community pharmacy and dentistry. The next meeting will focus on poly-pharmacy, falls and digital intervention.**	
6.	**Head and Neck Cancer Services in MK** **Context:** SW advised that due to primarily patient safety concerns arising from a number of SIs, long waiting lists and issues around clinical prioritisation at the current partner organisation for Head and Neck Cancer Services at NGH (Northampton), MKUH are seeking to establish a hub and spoke arrangement with OUH (Oxford). IR advised that services at the moment are commissioned by specialist commissioners and will likely move to the ICB in April 2023. The majority of patients are identified via ENT services. Roughly 50 patients a year are diagnosed per year at MK hospital who then need to undergo treatment. During early 2022 a number of incidents were raised where patients were having delayed or poor treatment via the current MDT model. Pathways are also disorganised with poor communication etc. These concerns were raised formally with commissioners along with the intention to realign the pathway with Oxford. The MK/Oxford pathway would enable appropriate surgery to continue at MK rather than pushing a centralised approach. This would also align with the direction of travel for radiotherapy services that will be provided on the site in MK in about 18-24 months' time. A BLMK pathway has been explored and it was agreed that this would be a longer term ambition. The BLMK CEOs have supported and approved this direction of travel and proposed model. **Discussion/Feedback:** • AR raised the complexity with multiple specialities, specifically mental and physical. The current MDT process – how do they currently access this support? IR advised that access would remain via CNWL and would need to become integrated into the pathway. KN said that there is a transformation programme ongoing and a piece of work is ongoing with ELFT and CNWL to look at how this can be strengthened. • KN asked what else can be done to help answer questions raised by specialist commissioning and help move this one. • BS raised that restorative dentistry is very important for patients and needs to be include within the MDT model. IR said that with the Oxford model we would need to have an in house service for this aspect of care but be clear on the MDT pathway. • EJ raised the speech and language therapy service provided to patients. IR said this would remain locally provided. • GZ raised patient safety and the SIs that have occurred - what else can be done while the changes are taking place. IR said that number of incidents are going	

	down due to the increased safeguards in place e.g. fail safe officers, reviewing patient by patient as necessary. IR said that advocacy for patients is key and the consultants in the service are aware of the issues to therefore check the granular detail of each aspect of the pathway. *RS joined the meeting after the discussion. SW confirmed a letter would be drafted to detail the discussion and support for the proposed model. RS advised that Oxford has commented that they wont be able to take on the service this financial year and a paper is awaited from Oxford for consideration.* **Recommendation from the Health and Care Senate:** **The HACS supported the proposed model for Head and Neck Cancer services in MK and agreed to send a letter from the HACS to Specialist Commissioning supporting the proposal.** **The HACS noted the concerns around patient safety and the measures put in place to try and mitigate these concerns, including fail safe officers.** **Outside of the meeting further research around the parity of mental health and physical health services will be explored along with the work around the transformation programme and also consider the impact of health inequalities.**	
7.	**Draft Committee Cycle of Business** **The Committee Cycle of Business was noted by the Health and Care Senate.**	
8.	**Communications from the Meeting** **Head and Neck Cancer** – Letter to be drafted by SW to Specialist Commissioners to support the proposed model. **Musculoskeletal Services (MSK) Health Needs Assessment (HNA) :** The HASC noted the HNA, specifically the role of community pharmacy and dentistry. The next meeting will focus on poly-pharmacy, falls and digital intervention.	
9.	**Review of Meeting Effectiveness** The Health and Care Senate were asked to feed back on the meeting effectiveness and if the discussion held addressed the questions asked. **Feedback:** A good multi-disciplinary discussion with key topics covered.	
10.	**Any Other Business** Future agenda item: Research and Innovation aspect of BLMK. Mtg ended at 2.08pm.	
Date and time of next meeting: Thursday 8 December 2022, 10.00 – 12.00 via MS Teams		

Approval of Minutes:		
Name	**Role**	**Date**
Sarah Whiteman	Chair	19.10.22
Health and Care Senate	Final Approval	

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 27.09.22.

Time: 1515-1700

Venue: MST

Minutes of the: Primary Care Commissioning & Assurance Committee (PCC&AC)

Meeting held in Public

Members:		
Name	Role	Initial
Alison Borrett	Chair / Non-Executive Member BLMK ICB	AB
Alexia Stenning	Associate Director of Primary Care Commissioning &Transformation BLMK ICB	AS
Amanda Flower	Associate Director of Primary Care Commissioning &Transformation BLMK ICB	AF
Dean Westcott	Chief Finance Officer BLMK ICB	DW
Helen Terry	Chief Executive, Healthwatch Bedford Borough	HT
Lynn Dalton	Associate Director of Primary Care Development BLMK ICB	LD
Mahesh Shah	Primary Medical Services Providers Partner Member BLMK ICB	MS
Manjeet Gill	Non-Executive Member BLMK ICB	MG
Marimba Carr	Deputy Director Public Health, Milton Keynes Council	MC
Nicky Poulain	Chief Primary Care Officer BLMK ICB	NP
Parul Karia (Dr)	Medical Director, Beds & Herts LMC	PK
Phil Turner	Chair, Healthwatch Luton	PT
Sarah Stanley	Chief Nursing Director BLMK ICB	SS
Tayo Kufeji (Dr)	Primary Medical Services Providers Partner Member, BLMK ICB	TKU
Tony Medwell	Head of Primary Care Contracting BLMK ICB	TM
Tracy Keech	Deputy CEO, Healthwatch Milton Keynes	TK
Sarah Whiteman (Dr)	Chief Medical Director BLMK ICB	SW

Apologies:		
Cartwright, Sally	Director of Public Health, Luton Council	SC
Diana Blackmun	Chief Executive Officer, Healthwatch Central Bedfordshire	DB
Felicity Cox	Chief Executive Officer, BLMK ICB	FC
Fiona Garnett	Associate Director of Medicines Optimisation BLMK ICB	FG
Lauren Sibbons	Senior Contract Manager NHSE	LS
Matt Mayer	Chief Executive Officer, Berkshire, Buckinghamshire & Oxfordshire LMCs	MM
Mike Harrison	Co-Chief Executive, Bedfordshire & Hertfordshire LMC Ltd	MH
Vicky Head	Director of Public Health, Bedford Borough, Central Bedfordshire & Milton Keynes Councils	VH

In attendance:		
Jill White	Senior Primary Care Contracting & Development Manager BLMK ICB	JW
Nikki Barnes	Associate Director of Estates Head of System & ICB Estates BLMK ICB	NB
Roger Hammond	Associate Director of Finance BLMK ICB	RH
Susi Clarke	Pc Workforce programme lead BLM KICB	SC

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies (Chair)** Chair welcomed everyone to the meeting. Apologies were received and noted. Chair explained the purpose of the committee was to seek assurance on the commissioning of primary medical services for the people of Bedfordshire, Luton & Milton Keynes. It would have oversight of the decision-making processes, challenge, assess and ensure that any risks are appropriately managed with the controls and mitigations in place to do so. Chair informed the committee that this was a meeting held in public and not a public meeting and therefore any questions were requested beforehand. No questions had been received. Members of the public attending could ask questions via chat in relation to the item being presented or under item 14. The meeting would be recorded for the purpose of the minutes. Members of the public were advised to mute speakers and as the meeting was being recorded, they may wish to turn cameras off. The meeting was confirmed as quorate.	
2.	**Relevant Persons Disclosure of Interests (Chair)** In future meetings the actual register for individual members will be shared but these are currently being collated by the Governance Team. Chair asked members to note: 1. any offers of gifts and hospitality in the last 28 days not registered with Governance & Compliance Team and 2. to declare any relevant interests relating to matters on the Agenda. No offers of gifts and hospitality or interests were declared prior to or at the meeting.	
3.	**Approval of Minutes 08.07.22. and Matters Arising (Chair)** **Committee approved the minutes.**	
4.	**Review of Action Tracker 08.07.22. (Chair)** Chair advised that all actions from the first meeting about the governance of the committee were completed or on the agenda today. **Committee noted the update on 08.07.22. actions.**	
5.	**Terms of Reference (Draft) (Chair)** **5.1 Primary Care Delivery Group (PCDG) & 5.2 Primary Care Commissioning & Assurance Committee (PCC&AC)** At its meeting on 08.07.22. the PCC&AC requested the development of Terms of Reference (TOR) for its executive led sub-group the Primary Care Delivery Group. The development of this TOR led to updates being required to the PCC&AC TOR. Updates approved by the Committee will be subject to approval by the Board. SW and NP agreed to discuss with MG how the Group aligns with the Health and Care Senate. **Committee approved the current draft PCDG Terms of Reference, updates to the PCC&AC Terms of Reference, and noted that both sets of terms will continue to be developed during 2022-23.**	
6.	**Primary Care Workforce Programme & Highlight report (Susi Clarke)** Update on progress against the programme's strategic workstreams; Wellbeing, Education, Training & Development, Retention, Career Development & Equality, Diversity & Inclusion, Leadership & Organisational Development and Attraction, recruitment, planning & supply. Report provided financial allocations, RAG rating and highlighted the critical success factors and risks or challenges for each of the projects / workstreams.	

1. Shine Project phase 1 to use the ShinyMind App to support staff and patients. Piloted small cohort utilising the App to train up multi professional teams within practices to have a comprehensive understanding of how this health and wellbeing, resilience and psychotherapeutic App would work with view to prescribing to patients.

   Results of phase 1 pilot were very impactful both in terms of staff wellbeing and retention and positive impact on patients. Business case to go to TILT and progress into phase 2. Health Education England (HEE) have agreed to fund nearly £500k to support roll out of project which would potentially impact 30 practices, 90 staff and over 15,000 patients. Mid to long term evaluation of the project will be shared with the committee.

2. Primary Care Networks (PCNs) currently updating workforce planning submissions. PCNs worked with ICB to review and ensure affordability. Final draft to be submitted next week. To note:
   - NHSE introduced more flexibility to the Additional Roles Reimbursement Scheme (ARRS). PCNs can now also utilise that funding to recruit GP Assistants and a Digital and Transformation Lead.
   - Additional HEE funding to increase First Contact Practitioner (FCP) supervisory capacity and extend number of hours for Paramedic Lead and Physiotherapy Lead.
   - PCNs supported to recruit roles and this capacity, expertise and experience on the front-line will provide wrap around support to engage, embed and retain staff.

3. There is funding to work with two PCNs to develop community pharmacy integrated lead posts – details being worked up.

4. Successful bid to support all primary care workforce with health and wellbeing pilot; also linked in with Dental Committee and community pharmacists and optometrists at an evening event. Plans for workforce team to visit dental practices as part of support.

5. ICB Primary Care Team supporting and sharing resources with urgent primary care providers for recruitment, retention and staff development; also ensuring access to staff digital platform and all commissioned services to support with recruitment.

6. Student pharmacist summer placement programme is in its third year and been so successful it has been adopted regionally. BLMK want to replicate across other professions. Secured 3-4 of pharmacists who completed placements in BLMK.

Challenges/risks in workforce programme:
- need to increase GP Trainee capacity to meet requirements of GP growth; particular challenges in Bedford Borough and team working hard to increase educative capacity
- workload demand and impact on retention and health and wellbeing of frontline staff
- estates capacity: ability to host new roles in practice and across PCNs.

- SC confirmed to PT that the Digital and Transformation Lead role was a Band 8a and capped at one role per PCN. GP Assistant role was a Band 4 and region to quantify numbers available to recruit per PCN.

- SC confirmed to MG that the apprenticeship strategy group would revisit discussions to broaden the approach on providers gifting of the levy. Red rating reflected capacity of team to progress but noted work with local government on nursing associate apprentices.

- Workload and capacity have limited the interest in the Post Graduate Diploma for General Practice Nursing which is funded by Continuing Professional Development Programme for existing staff. Team working with Martha Roberts, Chief People Officer to focus on securing workforce from BLMK community and raising awareness of training offers / careers available.

	▪ Due to limited funding the focus of the Shine project at this stage is specifically for general practice (three staff within each practice who are using prescribing platform for patients). All app licences opened to the system and enabled social care colleagues to access. Intention to do at scale with interest from different providers but need time to gather evidence base first. MC stressed need to ensure those who benefit most or whose patients benefited the most are prioritised. ▪ SC and NP confirmed to TKU (i) no guidance yet on recruitment of GP Assistants, e.g., could be recruited from outside existing workforce or via apprenticeship route dependent on needs and workforce aspirations of PCNs and (ii) that additional two roles were within PCN allocation but provided flexibility to use that funding whilst PCNs refresh workforce plans. **Committee noted the Progress outlined in the highlight report and that the Primary Care Delivery Group would be the forum to establish proactively collaboration to facilitate primary care enabled by the Primary Care Training Hub.**	
7. 7.1	**Primary Care Estates (Nikki Barnes)** **North Bedford Hub – Summary of Patient Engagement** Plan to relocate patient facing services from four of De Parys Medical Groups current sites to nearby Bedford Health Village to consolidate their team and service offer at a key hub facility and fully realise benefits of their merger to deliver significant benefits to patients. De Parys are the largest GP practice in BLMK with just under 40,000 patients and a PCN in their own right. Report describes patient engagement process undertaken to support development of full business case for the hub and provide assurance on the active engagement with patients. Survey ran from 25.05.22. to 20.07.22. with 11% of patients responding. Two key themes emerged from useful feedback received: (1) current levels of access for patients and (2) concern over future levels of parking provision and cost. One of the key objectives for relocation is to enable the practice to achieve efficiencies by operating from one site to reduce duplication, increase clinical capacity, offer more appointments and improved access. De Parys have a presence on site already and will be relocated to a larger facility (Enhanced Services Centre, ESC). Currently 18 parking spaces (staff and patients) to be relocated nearer to ESC; working with the practice on priority use of spaces. Transportation strategy developed for this scheme and for wider site which identified 257 spaces. Based on activity modelling for the hub and other services it should be manageable to operate within those spaces with additional supporting measures put in place. Leaflets to be sent to all De Parys patient households showing all available parking provision on site and nearby (free road parking) and bus and cycle routes. Equitable staff permit system to be established with other ICS partners based on site incorporating responsibility to encourage sustainable modes of transport where appropriate. Commitment to the practice to carry out joint robust review on access and parking within first six months of hub being open. Potential mitigations considered if issues are identified with parking of two large paid for car parks nearby. Potential negative impacts for patients analysed by feedback, particularly for disadvantaged groups which found a small number of patients felt negatively impacted which warrants further work and engagement to be carried out. All feedback incorporated into plans and ICB and partners will continue to review and listen throughout the project and beyond to ensure that the scheme delivers benefits for patients.	

	▪ Chair questioned designation of parking spaces between staff and patients? Spaces are not designated and are equally available for staff and patients. Utilisation of spaces will be monitored as part of the review. ▪ NB assured TK that the ICB continued to work closely with site partners to monitor parking and impact for patients to consider mitigations if required through the Bedford Primary Care Hub Programme Board. ▪ MG suggested 'champions' to look at services once build complete to ensure there aren't teams working separately within a capital build. **Members noted the progress made on the North Bedford Hub project, the outcome and response rate to the Patient Engagement exercise and the actions being taken to mitigate the concerns of the population in relation to the availability and cost of parking.**	
7.2	**Report from Estates Working Group – Prioritisation Update (Nikki Barnes)** Due to a significant number of primary care estates schemes across BLMK the ICB need to prioritise to ensure targeted investment resource where it will be most impactful including addressing inequalities and an affordable strategy. Paper sets out detailed criteria and process developed by the Estates Working Group (EWG) which is shared with the committee for visibility and assurance of process. Discussed and approved at the Primary Care Delivery Group (PCDG) today. Recommendation of a two stage criteria based on level of need, achievability and value of proposed solutions which is built on best practice and the national PCN prioritisation matrix tool. This will be part of a wider prioritisation process underway across the Integrated Care System (ICS) and will feed into multi agency hub schemes. System to review estates utilisation to understand how public sector assets are currently being used. Panel meeting to be held in mid-October to rank order of prioritisation of schemes and review affordability with the finance team. Plan to work within primary care delegated budget; in exceptional circumstances where there may be a need to spend more than affordable within budget it would be raised with the BLMK Finance & Investment Committee. Outcomes of panel to be ratified by PCDG in November and fed back to this committee for awareness. Committee discussed and raised following questions / points: ▪ Members of the Panel will be members of EWG and workforce team. NB asked for suggestions on how to have clinical engagement and manage potential conflicts of interest? LMC supported process and offered clinical input; PK and NB to discuss involvement required. SS, MS and SW also offered clinical support. ▪ DW supported recommendations and the need to ensure (i) all capital projects were aligned to clinical and operational strategies and affordable from a capital and revenue perspective going forward and (ii) transparency and equity across the system. ▪ Estate's strategy (2018) to be refreshed as primary care landscape significantly changed. **Committee noted the process, criteria and timeline agreed by the Estates Working Group for prioritising primary care estates schemes and the offer from PK, SS, MS and SW to either provide clinical representation to the Prioritisation Panel or discuss further management of any potential Conflicts of Interest for any clinical representatives.**	
8.	**Proposed BLMK Fuller Programme to implement the national recommendations (Nicky Poulain)** ICB Board agreed that PCC&AC would have oversight of the programme with the four respective place Boards critical to tactical and operational elements. Importance of the report outlined:	

- thriving integrated primary care systems built as locally as possible drawing on the insights, resourcefulness and innovations of residents, patients and their carers, local communities, local government, all NHS teams, CVSE providers and wider system partners, to successfully achieve the four aims of the Integrated Care System (ICS). Place Boards are pivotal with all 23 PCNs aligned to the four places
- move towards a more psychosocial model of care and realignment of health and care system to a population-based approach to address inequalities
- alleviating system pressures – highest priority to agree scaled and streamlined model to deliver urgent same day primary care. Working with Place Boards, PCNs, community and mental health providers, integrated urgent care providers and community pharmacists to improve access offer to patients
- access programme is multi-operational and includes digital, telephony, health and care teams using shared patient notes (total operability by March 2023), improved communications and engagement with patient guides, implementing community pharmacy GP consultation service, improved co-operation with integrated urgent, emergency and 111/999 providers to manage category 3 & 4 calls
- further development of multidisciplinary health/care teams to work with GPs to provide continuity of care to people with more complex needs (proactive and personalised offer)
- integrated neighbourhood (Fuller) teams from PCNs, wider primary care providers, secondary care teams, social care teams, domiciliary and care staff working together to improve health and wellbeing of local communities and tackling health inequalities
- emphasised importance of work at place level but where makes sense have one system view (estates, workforce, digital etc.)
- full plan to be shared at the next meeting and a refreshed and refocused primary care strategy to be developed.

Committee discussed and raised following points:

- Confirmed to TK that all patient records would be accessible across BLMK from March 2023 and that some were already accessible. Digital strategy, information governance and protecting individual's information was key and was shared with ICB public board.

Committee noted the proposed programme approach and supported the approach for the principle of subsidiarity. Committee to be kept up to date with the implementation as a standing item.

8.1 **Report from Primary Care Access Oversight Group (Amanda Flower)**

Presented BLMK Access Oversight Group's report to provide assurance and as part of the fuller workstream for access.

BLMK on average seeing higher activity and appointments in general practice than pre pandemic and ranks highly in terms of percentage of face-to-face appointments delivered to its population. GP Patient Survey (July 2022) provides areas of focus on patient experience where improvement required. BLMK ICS below national percentage of population rating themselves as having good experience at practice and has a higher percentage of population who describe having difficulties getting through by telephone compared to national average.

Data and indicators used as part of the programme include total no appointments offered; % face to face appointments; total number 111 calls from registered population in and out of hours; total A&E attendances. Committee updated on key points of programme:

- Dr Monjour Ahmed appointed as BLMK Strategic Clinical Lead for access programme
- each place has included a place clinical lead role to focus on access who will work with Dr Ahmed and each other to network and support the programme
- multi-pronged approach to support practice access through the place team, ICB management team and practices through place-based arrangements

	- major communications focus to describe the offer of general practice to the population and stakeholders; monthly briefing with place focus using available data. Engaging with clinicians to provide videos and insights into workings of primary care to support communications - significant part of Fuller recommendations is how to improve access to urgent same day care. Developing transformation plan with clinical leaders and stakeholders for how we deliver offer provided by general practice and commissioned services (111, out of hours services, urgent treatment centres) - programme built around data driven approach and other sources of information on offers practices making to population and how they utilise offers of support (local and NHSE) - developing clear plans for practices with significant challenges (workforce, estates etc) and how they can be supported - GP patient survey: summarised reports shared at place meetings; practices and PCNs re-viewing to consider improvements to be made locally and how they can be supported - facilitating sharing of good practice with practice teams through webinars and events chaired by clinicians to launch in October - collaborative working with Training hub to support recruitment and shift fill of clinical roles - continue to work locally to develop GP Community Pharmacy Consultation service (GPCPCS) and engage practices - all work overseen by fortnightly oversight group (ICB management team plus subject matter experts). Bimonthly stakeholder group has representatives from across wider system and takes a deep dive approach on areas discussed - Regular updates through the developed place board structure. ▪ MS questioned scope to consider direct CPCS rather than via GP or 111. It was noted that BLMK ICB comply with the national programme specification. The ICB believe there is an opportunity to consider how we support the population to access directly thereby supporting self-management which is a crucial part of access programme and a part of work taking place with region on what potentially could be done once ICBs have responsibility for pharmacy in 2023. LD to share regional level thinking with MS and colleagues. ▪ AF to share system comparison using East of England average for indicators where data available in next report. ▪ Recognised that telephony systems is a priority area for improvement in BLMK. Range of interventions supporting practices with existing phone systems to ensure functionality plus benefit of national programme to introduce advanced telephony. Confirmed to HT not possi-ble to measure repeat/drop out calls on older systems. NHSE have requested ICBs to report back on whether cloud-based telephony in place and proportion of practices with it. Focus on digital developments for telephony and wider digital offer to be presented to the committee. ▪ Data available for analysis of how and why population trying to access GPs and types of intervention requested. NP confirmed areas of analysis undertaken on mental health, chil-dren and frailty and interventions already in place with 111 for direct numbers for care homes and mental health. **Committee noted the primary care access oversight group update and next steps.** **ACTION9: Focus on digital developments in terms of telephony and wider digital offer as future agenda item for the Primary Care Delivery Group.**	
9.	**Primary Care and Digital Risk Registers (Jill White)** Risk registers for the primary care directorate and the digital transformation programmes are shared for assurance that risks have been correctly identified and are being suitably managed. Updates since paper written:	

	- Corporate Risk Register 76: System response to 111 resilience and capacity. Monitored by Primary Care register as responsible for implementing majority of actions with system support. - 600 (practices who do not belong to a PCN) and 601 (change in FCP competency criteria) closed. Implemented all mitigations and reduced risk; managed as business as usual. - 258 (impact of covid vaccination programme on business as usual) closed. Community pharmacies are now main provider for programme and part of normal business rather than emergency response for GP practices. - Four new risks 619, 620, 621 and 623 reflect discussions held under today's agenda items. - 621 closed. Issue resolved by hospital system to enable Evexia to interface on blood results with practices and PCNs. **Committee noted that risks relating to the primary care directorate and digital transformation programme were being identified and managed by the relevant teams and that all risks continue to be logged and monitored in the 4Risk system.**	
10.	**Primary Medical Services Delegated Primary Care Financial Report (July 2022) (Roger Hammond)** Report for assurance provided a high-level summary of July 2022 delegated primary care financial position. It is the role of the Committee's subgroup Primary Care Delivery Group) to scrutinise finances, discuss risks and make informed decisions in overseeing the delegated budget to promote increased quality, efficiency, productivity and value for money across primary care services. Chair stated that where risks rated red the Committee required understanding and assurance that controls and mitigations were in place. RH explained red rating triggered by overspend and where this was under the control of the ICB and where outside its remit. Red ratings invariably offset by sufficient contingency to manage any unexpected movements in expenditure as the year progresses. This is monitored month on month and any changes would be discussed at the Delivery Group and Committee made aware. **Committee noted the July 2022 delegated primary care financial position.** **ACTION10: Committee to confirm if format and detail were sufficient for assurance or a different approach was required.**	
11.	**Annual cycle of business (draft) (Chair)** **ACTION11: Committee were asked to review and feedback back to LB.**	
12.	**Communications from the meeting to all partner organisations (Chair)** Committee did not identify any additional communications required from this meeting to all partner organisations. Chair confirmed communications discussed under agenda items: Item 7.1. North Bedford Hub: Patient engagement report discussed and will be made available online and shared with all who requested a copy including key local stakeholders and Item 7.3 Estates prioritisation update: estates team will communicate with practices/PCNs for additional scheme information and will update them by the end of September. **Committee noted there were no additional communications to be shared.**	
13.	**Review of meeting effectiveness (Chair)** Chair asked members to feedback on whether the quality of the papers was sufficient to allow them to discharge their duties and the expectations of each paper? **ACTION12: Members to feed back to Chair / LB.**	
14.	**Questions from the Public (Chair)** No questions received from the Public prior to or at the meeting.	
15.	**Any other Business (Chair)**	

	No other business was raised.	
16.	**Date and time of next meeting**: 09.12.22. Meeting held in Public 1415-1615 via Teams.	

Approval of Minutes:		
Name	Role	Date
Alison Borrett	Chair	20.10.22.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: Friday, 02 September 2022

Time: 11:00 – 12:00

Venue: MS Teams

Minutes of the: Quality and Performance Committee

Members Present:		
Name	**Role**	**Initial**
Andrew Blakeman	Chair	AB
Anne Murray	Chief Nurse	AM
Claire McKenna	Director of Nursing, East London Foundation Trust	
Davina Culley	Assistant Director of Nursing, Central North West London NHS Trust (representing Helen Willetts who will be replaced by James Smith, new Director of Nursing for Diggory)	DC
Glenda Hall	Head of Service, Cambridge Community Services for 0 – 19 and Looked After Children	GH
Liz Webb	Deputy Chief Nurse, Cambridge Community Services	LW
Mahesh Shah	Partner Member, Primary Medical Services	MS
Maria Laffan	Deputy Chief Nurse	ML
Maria Wogan	Chief of System Assurance and Corporate Services	MW
Martha Roberts	Chief People Officer	MR
Sarah Burgess	Performance Manager	SB
Sarah Whiteman	Chief Medical Officer	SW
In attendance:		
Name	**Role**	**Initial**
Beverley Husbands	Secretariat (Minutes)	
Charlotte Davies	Child and Adolescent Mental Health Services Commissioning Lead	CD
Claire Ferreira	Compliance and Audit Manager, Planned and Specialist Care	CF
Duncan McConville	Senior Commissioning Manager, Planned and Specialist Care	
Emma Hardwick	Director of Midwifery, Bedfordshire Hospitals	EH
Glenda Hall	Head of Service, Cambridge Community Services for 0 – 19 and Looked After Children	
Sanhita Chakrabarti	Assistant Director of Public Health	SC
Simon Hardcastle	Associate Director, Quality and Safeguarding	SH
Tiina Korhonen	Clinical Services Programme Lead, Clinical Effectiveness NHS South, Central and West Commissioning Support Unit	
Apologies:		
Name	**Role**	**Initial**
Luke O'Byrne	Service Manager, Adult Commissioning, Quality and Care Placement, Luton Council	
Lorraine Sunduza	Deputy Director of Nursing, East London Foundation Trust	
Jo Meehan	Associate Director, Child and Adolescent Mental Health Services, East London Foundation Trust	

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** • The Chair welcomed everyone to the meeting. • Apologies were received and noted as above. • The meeting was confirmed as quorate. • The Group was advised the meeting is being recorded **Quality and Performance Committee - Introduction** 1.1 The purpose of this Committee is to provide assurance to the Integrated Care Board (ICB) that objectives are being met in relation to Quality and Performance across Bedfordshire, Luton and Milton Keynes. 1.2 If objectives are not being met, there will be awareness of presenting risks and mitigating actions. If mitigating actions will not significantly reduce or eliminate associated risks, they will be flagged to the ICB. 1.3 The Committee must determine whether services are being managed effectively across the system and hold partners to account, where appropriate. 1.4 This Committee is not a decision-making body.	
2.	**Relevant Persons Disclosure of Interests** 2.1 Members were asked to confirm all offers of Gifts and Hospitality received in the last 28 days were registered with the Governance & Compliance team. None were declared. 2.2 Members were also asked to declare any relevant interests relating to matters on the agenda. None were declared.	
3.	**Approval of minutes from 15 July 2022 , Review of Action Tracker and matters arising** 3.1 The minutes from 15 July 2022 were approved as an accurate recording. There were no matters arising.	
4.	**Review of Action Tracker** 4.1 **Item 1** – Committee membership - In progress – Lorraine Mattis was appointed as Associate Non-Executive member and added to future meetings 4.2 **Item 2** – Metrics Dashboard – updated version included in meeting pack, MW explained the dashboard development is an ongoing piece of work for this committee and other forums across the system and welcomed comments /feedback from the group. **Close** 4.3 **Item 3** – Audits Annual Cycle of Business – AB clarified the reference to audits is internal rather than clinical. AM explained the reference was to outcomes of previous deep-dive audits that can be fed into the forward planning of the committee and not a new audit schedule for the committee.	
5.	**Risk Register** 5.1 ML explained the information on risks is correct at time of printing however positions may have changed by the time of this meeting. ML briefed the group on the key areas of concern linked to Corporate and Operational Risks 5.2 MW added that work is underway to develop an assurance framework for the ICB that covers high-level strategic risks. 5.3 AB – does the current process of risk identification and mitigation meet the remit of the Quality and Performance Committee? 5.4 The group recognised ongoing developments in risk processes and agreed the risk register gives adequate assurances that there is collaborative, partnership working to identify and report system risks and gaps in service, develop	

	informed and effective risk mitigation and action planning, with regular monitoring and management across the system.	
6.	**Patient Safety Incident Response (PSIRF)** 6.1 ML - the Patient Safety Incident Response Framework, was published nationally in August 2022. It will replace the Serious Incident Framework and gives 12 months for implementation. The Framework represents a cultural change and approach to patient safety responsibility, response and accountability. 6.2 There will be close working and support for partner organisations with close down of the current systems and development and oversight of new PSIRF plans based on current knowledge of local and system safety concerns, Serious Incidents, policies, processes, etc. It was recognised there will be challenges during the initial stages of changing between the two systems, however there is significant learning available, nationally, from early adopter sites. 6.3 The Framework was discussed at the System Quality Group yesterday; ML was nominated as the Patient Safety Specialist for the BLMK system with an initial peer support group planned for 27/09/22.	
7.	**Performance and Quality Report** 7.1 SB gave a comprehensive update and overview of the 100-day Performance Indicators across the system. **Action: SB to provide national and local data to benchmark performance against ambition for next meeting** 7.2 GD – the update is showing a continuing trend of system pressures linked to the Urgent Care System (UEC). The biggest risk is assurance around 78-week delivery, due by March 2023 and Ophthalmology patients. Planning is underway for delivering effective management of Ophthalmology waiting lists via the Elective Recovery Board. Thought needs to be given to how the system is mitigating Urgent Care pressures in response to the demand the system is encountering. 7.3 A system-wide Winter Plan is under development for sign off by 26th September along with a comprehensive plan to address seasonal pressures and system resilience. A plan was submitted to bring additional capacity of 77 beds into system, which NHSE approved. 7.4 There are serious concerns regarding the interface between health and social care, specifically in the areas of no criteria to reside and delayed discharges. At Board level, a conversation is needed about how this arrangement is working across the system and how partners are working to support and enable system delivery and flow. 7.5 MW – would it be helpful to have a longer-term view of system-wide performance with information from statistical process control charts. Risk based approaches may add value discussions to identify and collectively address big performance risks. Provider voices in the group will help with views on how the system is working. 7.6 AM – UEC risks have been raised across the system and is an important area for a focused a deep dive, it is also necessary to capture and recognise the implications of patient and workforce experience and outcomes; findings should be presented at the next committee meeting. 7.7 MR – workforce is recognised another high-risk area, i.e., capacity in health, social care, Urgent Care and Emergency Care; thought needs to be given regarding how to share information across all relevant committees.	**SB**

	7.8 AB – the group received accurate and comprehensive data, information and plans for identified strategic risks and system pressures in areas of acute and social care **Action: Deep Dive audit of UEC risks across the system to include focus on patient and workforce experience** **Action: Determine next steps in developing longer-term practice and use of committee, views and objectives**	
8.	**Children and Young People** **Mental Health Deep Dive Summary** 8.1 CD – gave a comprehensive overview of the mental health deep dive which focused on demand and capacity, i.e., referrals and workforce with a focus on mitigations for demand and capacity issues and 5-year investment incomes. 8.2 There is increased demand for all elements of specialist services for children and young people with significant increases in acuity; crisis presentations and the need to be seen sooner by more highly skilled, specialist clinicians 8.3 Nationally, mental health services are seeing up to 50% increase in demand for access to more intensive mental health support sooner. There are significant cost pressures across the system and a lack of clarity on funding streams beyond 2023/24. There is concern on delivering a balanced CAMHS plan in light of a £1.8 million gap in funding resources. 8.4 There is a need for greater understanding of early crisis intervention and prevention services across the system. There are 15,000 children in the system with unmet needs. 8.5 SH - strategic priorities for children and young people, including children with complex needs, learning disability and autism, need to be included as part of the wider agenda for Winter Planning, 111, acute presentations, challenges with children, young people and their families, accessing primary, etc. GD will liaise with performance colleagues to ensure children and young people are included in the Corporate Winter Plan. 8.6 MW – The Integrated Care Strategy is under development with a workshop planned for 21st September, focusing on the Starting Well strategy, outcomes from this deep dive will feed into strategy development. 8.7 MW – how are issues identified in the deep dive being managed? Response - starting point is the BLMK ICS Data Insight Pack which identifies demand and unmet needs, will also be attending strategy workshop on 21/09/22 **Special Educational Needs and Disabilities (SEND) -** Position paper in relation to statutory duties and assurances for children with SEND 8.8 Through system wide work across commissioning and quality, there are now place based posts, jointly funded in programme management and commissioning. Joint strategies were signed off by the four local authorities and the ICB 8.9 In 2018 Luton, Central Bedfordshire and Bedford Borough Councils had inspections; all required Written Statements of Improvement. Bedford Borough is no longer under scrutiny; Central Bedfordshire still requires remedial action in three areas, Luton Council re-inspection expected in autumn. Milton Keynes got an excellent report in 2018, and is due for reinspection next year **Safeguarding – Looked After Children** 8.10 There are challenges getting assessments completed in a timely manner i.e., Initial Health Assessments (IHA) and Review Health Assessments (RHA), for children placed in Luton from other counties due to continued vacancies and lack of capacity across services. There is ongoing work with General Practice collaboratives to identify GP support for out-of-area assessments – training	

	will be provided. October 1st, practices will be extending appointment times to include evening and Saturday appointments; now is the time to have conversations about the Children in Care Model. 8.11 The request is for the committee to note the challenges with completing Initial Health Assessment for out of county placements, the impact on service provision and capacity and mitigations to improve service delivery. 8.12 GH – provider services are looking at all areas where improvements can be made, working closely with local authority colleagues to improve referral time frames; noted is the high number of "was not brought" which impacts on appointment slots and timely completion of initial assessments. An extra piece of work is needed with local authorities to support foster parents to bring children to appointments.	
9.	**Local Maternity Neonatal System** **SC –** the paper is presented to provide assurance on the functions of the Local Maternity Neonatal System Board and the current challenges in the maternity system. 9.1 The maternity system is currently under significant scrutiny, nationally and regionally (Ockendon National Review Report). A joint, system-wide approach across Bedfordshire, Luton and Milton Keynes was started four years ago following the Better Births National Maternity Review Report. 9.2 There are significant workforce challenges, the national mandated care model across both hospital trusts is under pressure with recruiting; maintaining training standards is also impacted by workforce issues and delivery of a digital workforce strategy to drive improvement is presenting as a barrier for much of the work underway. Patient surveys, i.e., Voice of Mums have identified gaps in services that need addressing. 9.3 EH – the Perinatal Mental Health Programme has been very successful. Effectiveness, responsiveness, engagement within maternity and neonatal services has been good. Maternity services were able to evidence compliance with some of the immediate and essential actions from the Ockendon report. A coordinated approached to shared learning was developed for staff from all disciplines, which also covered particularly vulnerable areas of informed consent, and cultural competency. Cultural Key Workers have been established on the Luton and Dunstable sites and extending the scheme further is being explored. Noted there has been a big increase in maternity services funding to support transformation of services and good work is underway to address service gaps.	
10.	**Transforming Care** 10.1 AM – Lakeside Hospital closure – Brookdale Care closed the hospital due to significant changes in the service delivery model for learning disability and mental health service users and ongoing financial viability. BLMK ICB, as the host, commissioner worked with over 20 other commissioners across the country to oversee the successful transfer of 29 patients to alternative placements, which was completed within six weeks. Thanks are extended to Maria Laffan and Kaysie Conroy for their input to the successful completion of this process which received very positive feedback. A learning event is planned for later in the year, a final report will be prepared and shared nationally and regionally. 10.2 AM – Completion of learning disability health checks is a priority area for improvements; there is close working with primary care colleagues to ensure all people with learning disabilities are offered a health check appointment by the end of September. A Project Officer is supporting this work. 10.3 Length of Stay audit – encompassed a review of all patients, children and adults, with a learning disability, including consideration of their physical, mental, psychological and health needs and future plans, in an acute setting and	

	further review of those remaining in an acute setting past their anticipated discharge date. Noted there are challenges with the number of children who are inpatients, the trajectory is 3 but actual is 8. Through action and recovery plans, we are working closely with the Integration and Personalisation team to complete Care, Education and Treatment Reviews (CETR) to ensure appropriate discharges.	
11.	**Serious Incidents and Never Events** 11.1 ML – trends in mental health incidents e.g., unexpected deaths and associated suicides, are picked up through the Mental Health Transformation Boards. There is regular monitoring and a programme of work planned with providers to look at interpretations of serious incidents in light of the upcoming changes to reporting with the new Patient Safety and Incident Response Framework	
12.	**BLMK Area Prescribing Committee Minutes** 12.1 The Committee noted the Area Prescribing Committee minutes	
13.	**Gamete Storage Policy** 13.1 The Committee considered and supported the Gamete Storage Policy. The Group approved the Policy	
14.	**Review of Effectiveness** The Chair asked the group to respond to the question "what could be even better if…" Responses • We get a mix of people to attend this meeting including front line staff, so they have an experience of what the committee meetings are like • I learned a lot about areas I wouldn't normally hear about • Understanding how our performance impacts on delivery through service user feedback, i.e., start off with the impact of service delivery on our service users • Provider voice heard more strongly at the committee meetings • Service user representation on this committee • Make sure that every single item, in the function of a quality committee, brings us back to" what does this mean" and "focus on the patient experience" • Thinking about the experience of our employees in the quality agenda, having conversations with people who are providing services and hearing the voices of the people who work for the providers • Providers in attendance are clear about their role in the committee • We follow up on MW's creative suggestions about our strategic approach to assurance	
15.	**Any Other Business** 15.1 Adding deep dive into UEC Risks at next meeting 15.2 Consideration of the strategic issue for the Board and Health and Care partnership around CAMHS, i.e., developing a strategy	
	Date and time of next meeting **Date**: Friday, 02 December 2022 **Time**: 10:00 – 12:00 **Via**: Microsoft Teams	

Approval of Minutes:		
Name	**Role**	**Date**
Quality and Performance Committee	Final Approval	Click or tap to enter a date.

Andrew Blakeman	Chair	10/10/2022

Meeting closed 11:50

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. MG 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 MoU before it is presented to Board for approval.	**ACTION 11: 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

ICB in PUBLIC - Annual Cycle of Business as at 11.11.22

	Accountable Person (name on agenda)	27/01/2023	24/02/2023 EGM	31/03/2023
Strategy				
Fuller Stocktake - after 29/7 quarterly update on implementation	Chief Primary Care Officer			✓
People Strategy	Chief People Officer	✓		
Operational				
Quality & Performance Statement/Report	Chief Nursing Director	✓		✓
Finance Report	Chief Finance Officer	✓		✓
Resident's Story	Chief of System Assurance & Corporate Services	✓		✓
Governance				
Board Assurance Framework	Chief of System Assurance & Corporate Services	✓		✓
Reports from Place Based Boards: Bedford Borough Central Bedfordshire Luton Milton Keynes	Local Authority CEOs	✓		✓
Accept new delegated authority for Primary Medical Services			✓	
Committee reports	Committee Chairs	✓		✓
Annual Cycle of Business	Chair	✓		✓
Communications from the meeting to all ICS partner organsations	Chief of System Assurance & Corporate Services	✓		✓
Questions from the Public	Chair	✓		✓
Review of Meeting Effectiveness	Chair and all Board Members	✓		✓